

Final Draft

**THE NEW HAMPSHIRE
HEALTH CARE SYSTEM:
GUIDELINES FOR CHANGE**

MAY 1, 1998



**DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Planning & Research**

Executive Summary

In 1995, in response to changes in the health care system, the Department of Health and Human Services (DHHS) drafted legislation which was approved and signed into law that directed the Department to prepare "a comprehensive and coordinated system of health and human services as needed to promote and protect the health, safety and well-being of the citizens of New Hampshire." (RSA 126A) The Department responded by creating a statewide Health Care Planning Process - the goal of which was to develop a State Health Plan - to be conducted by the newly established Office of Planning and Research. During the past two years over a thousand New Hampshire citizens have been involved in 7 community councils, 22 focus groups, 10 town meetings, symposia¹ and reviews of the planning reports.

We wish to express our sincere gratitude to those citizens, health and social services professionals, and elected officials who participated in the health care planning and made this report (and the other reports that compose the *New Hampshire Health Plan*) possible.

(See Acknowledgments - APPENDIX A - for a list of all who participated in the development to date of the New Hampshire Health Plan).

The Purpose of This Report

The *New Hampshire Health Plan* consists of a series of reports (each builds upon the previous reports) that will be updated, refined and added to as the health care environment continues to change. New legislative, administrative and regulatory initiatives will result from the *Health Plan* or these initiatives will drive the development of additional studies and reports. *The New Hampshire Health Care System: Guidelines for Change* is the seventh report in this series of planning reports - all part of the *New Hampshire Health Plan* - issued by the Department.

Guidelines for Change will be widely distributed. Its intended audience(s) are those who participated in the community councils, legislators and policymakers, the business community, interested members of the public, health and social services providers and other branches of State Government.

This report has four primary goals:

- to promote improvement in the health status of the State's citizens;
- to provide a framework for policy makers to manage change within the health care system, balancing the roles of the State, the Community, and the Market;
- to offer and promote strategies for action which respond to the need for comprehensive statewide health reform; and

- to promote and encourage broad participation from citizens, providers, purchasers and public officials.

(See also Health Care Reform in New Hampshire: 1986 - 1998 - APPENDIX B - for a concise history of past and present New Hampshire initiatives in health care reform, including events that led to the Health Care Planning Process).

The Structure of This Report

The *New Hampshire Health Care System: Guidelines for Change* is divided into the following sections:

Executive Summary

Introduction

I. New Hampshire's Health Vision, Values and Goals

II. Strategies for State Action

III. Appendix

The Definition of Health

The participants in the Health Care Planning Process and the Department of Health and Human Services decided that any consideration of the health care system should be based on a positive definition of the terms "health" and "health care." Health is not merely the absence of illness; it is the presence of well-being or the realization of potential. Health care should not be understood merely as treatment for illness; it should include necessary and appropriate services, medical, social or other, that is intended to promote the highest possible level of function and independence for an individual. Health care should address the whole person. Its goal should include physical, emotional and spiritual growth, satisfaction and fulfillment - the flourishing of the individual.

For these reasons, the term "health," as used herein, will have the same definition as that put forth by the World Health Organization:

"A state of complete well-being, physical, social and mental, and not merely the absence of disease or infirmity."

Vision

In order to ensure that New Hampshire residents enjoy the highest quality of life attainable, the *New Hampshire Health Plan* will promote access for everyone to necessary and appropriate health and social services.

Health System Values

In order to find out what values New Hampshire citizens held most important regarding the health care system, the Office of Planning and Research used two sources. The first and most significant source was the extensive set of discussion groups that were conducted throughout the State.² The second source was derived from work conducted by the seven District Councils. The participants in each District Council were asked to discuss and agree upon a set of statements describing the functional characteristics of an ideal health care delivery system by answering the question: What would an ideal health care delivery system do?

The purpose was to elicit the expression of core values that could be used to set requirements for the health care system in the future.³ As part of this endeavor, questions were presented to the discussion groups:

What do you consider to be essential in any health care system?

What do you consider to be intolerable?

The five core values common to both of these sources are listed in Table 1.

Table 1

New Hampshire Health System Values	
1.	Every New Hampshire citizen will have access to necessary health care services regardless of individual circumstances.
2.	The health care system will be based on desired health outcomes as determined by well-defined indicators for measuring health.
3.	The health care system will emphasize quality of care and focus on controlling costs.
4.	Health care consumers will be empowered and assume primary responsibility for their health and for the care they receive.
5.	Communities will play a role in the organization and integration of health systems and in the delivery of health care services.

Health Goals

After an extensive discussion of the definition of health and the indicators by which health status ought to be measured, the members of the District Councils were asked to

articulate a vision and goals statement for the health status of New Hampshire citizens. The result was the following statement.

To ensure that New Hampshire residents will enjoy the highest quality of life attainable, **the New Hampshire Health Care Plan will promote universal access to necessary and appropriate health and social services.** The Health Care Plan will be a strategy for achieving the Health Status Goals (see Table 2). The Health Status Indicators that are associated with the goals will provide benchmarks for measuring New Hampshire's progress in achieving health and well-being. The Plan, the Goals, and the Indicators will be developed with input from hundreds of New Hampshire citizens.

Table 2

Health Status Goals	
1.	New Hampshire residents will live with independence and satisfaction as contributing members of their communities.
2.	New Hampshire residents will live with a minimum of disease and disability.
3.	New Hampshire residents will live in safe and supportive homes and communities.
4.	New Hampshire residents will live free of environmental hazards.
5.	New Hampshire residents will have the educational and economic opportunities they need to realize their full potential.
6.	New Hampshire residents will choose behaviors which contribute to health and well-being.

Strategies

The strategies for State Action focus specifically on the health care system. Four primary strategies based on the vision and goals are outlined in this section:

- A. promoting access to health care coverage while controlling costs;
- B. protecting and empowering consumers;
- C. re-defining public health; and
- D. partnering with communities.

There are a total of 27 recommendations (see Appendix C on page 90) for implementing these strategies. Each recommendation is followed by a brief explanation. Some of the

recommendations can be prioritized and achieved under existing administrative authority. Others will require legislative deliberation and action.

A. Promoting Access to Health Care Coverage While Controlling Costs

describes the challenge in addressing the problem of the uninsured through a voluntary approach. Any efforts must be coordinated with other health reforms so as to avoid expending resources on initiatives that fail to eliminate the root of the problem or that merely shift the problem from one area to another. The strategies and initiatives outlined here are designed to improve access to health insurance coverage and control costs through incremental reforms that address all aspects of the health insurance market and that are coordinated to achieve maximum combined effect.

This strategy has three components:

1. pursue continued insurance market reforms to enhance competition and discourage risk selection (e.g., interagency monitoring of the health care market, monitoring the number of uninsured, standardized benefit packages, and risk adjustment);\
2. organize purchasing activities to enhance competition (e.g., a small business health insurance purchasing alliance); and
3. subsidize private market coverage and support safety net providers and delivery structures (e.g., a two phase expansion of health insurance coverage, definition of the scope and funding sources of safety net services, coordination of health-related non-medical services with medical care, review of the role of Certificate of Need, and establishment of standards of adequacy for the delivery system).

B. Protecting and Empowering Consumers describes how this could be accomplished in a market-driven health care environment. The market functions best when there is a choice of products and providers and sufficient information for consumers to make informed decisions.

Recently released national data shows that four out of five employers who sponsor health insurance offer only one plan to their employees. The health care industry in New Hampshire is undergoing an historic transformation as more people enroll in HMOs and other types of managed care plans. The State saw a 25% increase in underwritten managed care enrollment between 1994 and 1995, and an increase of 18% between 1995 and 1996. In the small group market that shift has been dramatic - during 1998 HMO enrollment for this population is expected to reach 80 percent. CIGNA/HealthSource and Blue Cross/Blue Shield, who purchased Matthew Thornton in 1997 accounted for 77% of HMO enrollees in 1996.

Most states, including New Hampshire, do not have information systems capable of monitoring or supporting health reform. Funding, data comparability, and cooperation of providers and insurers will be issues the State must address if it is to construct a viable health care information system.

This strategy has four components:

1. establish a system for conflict resolution between consumers and providers with their health plans (e.g., mediation and consumer hotline);
2. assure the quality of care (e.g., organization/collaboration of interested parties and a coordinated State monitoring policy);
3. develop a State information infrastructure (e.g., review of health status, State and market functions, community concerns, and private development of information); and
4. assure the solvency of risk-bearing entities (e.g., licensure of risk-bearing entities according to the number of covered lives, structure and percent risk assumed, guidelines for transferring risk from one entity to another and self-insured plans).

C. Re-Defining Public Health in the Evolving System examines the traditional public health roles within a managed care delivery system.

In 1996, 39 percent of New Hampshire's population was enrolled in HMOs (includes underwritten managed care and self-funded business). The health status of enrollees in an HMO becomes a critical determinant to the financial success of an HMO. As the portion of the population enrolled in HMOs increases, the domain of HMOs and public health may overlap. Since the State's residents are rapidly choosing to receive care from two HMOs, these HMOs can - and some would argue should - offer some population-based services that were traditionally provided by public health. In addition, these HMOs may have to perform some of the public health evaluations of the effectiveness, accessibility and quality of personal and population-based services.

This strategy has four components:

1. redefine public health;
2. determine the impact that private and community reorganization of health care services have on public health;
3. determine which public health functions should remain, be expanded, altered or eliminated in light of private and community reorganization of health care services; and
4. determine whether the private sector should be held to a different standard than the public sector.

In the new health care system, the resources allocated to public health services may be inadequate or excessive depending upon how public health roles are altered.

D. Partnering with Communities addresses how and why the voice and needs of the community should be a part of the new health care system. The discussions during the planning work raised two basic questions about both communities and the State's involvement:

- What is a community - what is it that the State should be listening to and promoting?
- Why should the State support community involvement in the health care system?
- When these questions are fully answered through the planning work, the State can begin to consider how it should assist communities and what form the assistance should take. The State can also determine what it can expect from communities: the way they can balance and augment the actions of the State and the market. This will also allow the State to work with communities to clarify expectations for private entities that claim a community role. For example, non-profit hospitals are described as community organizations that provide community benefits. In return, these institutions do not pay taxes; that is, they receive a public subsidy. However, neither the State or any independent body representing communities define the community benefits that non-profits should be providing.

This strategy has two components:

1. sustain community involvement in health care delivery; and
2. define and protect community benefits.

Next Steps

The planning process does not end with the production of this report. This report is not done. It represents a "final draft" that incorporates the review of the participants in the planning work to date. Additional review and revisions will be necessary. Much work remains to broaden participation in the coming months, particularly to gain the perspectives of the business, legislative, and market communities. Further involvement of other State agencies will also be sought.

Determination of the action steps and stages of implementation to achieve the strategies in Section II (*Strategies for State Action*) will be done in concert with all stakeholders in keeping with the participatory and iterative nature of the planning process. This report proposes the structure(s) that will allow for continuous and ongoing planning with participation of communities, the State, and the market. It is not a detailed blueprint of how the New Hampshire health care system will develop. Health planning in New Hampshire has become a verb instead of a noun. Instead of a detailed blueprint, it has evolved to a continuous process that permits and directs movement towards general goals.

At this point, some of the recommendations in Section II are being accomplished in the short-term; others will be dependent on actions that will necessitate a long-term view. Priorities will need to be set in concert with other interested stakeholders. Decisions will need to be made as to which recommendations can be achieved via administrative, regulatory or legislative action.

The same open and collaborative course that brought the Health Care Planning Process to this point will be used with work that remains to be done. Input from a broader audience will help refine and improve the process and the strategies.

The *Guidelines for Change* represents the culmination of one phase of the health planning work. At the same time, it also represents the beginning of the next phase.

¹Symposia topics included: prioritizing health care needs, the role of the community, long term care and health and social service networks.

²Twenty-two discussion groups served as proxies for the State's citizens. The groups ranged in size from 6 to 40 members. Some of these groups consisted of individuals with similar backgrounds or concerns (e.g., hospital administrators or individuals with disabilities) or mixed gatherings of citizens representing the concerns of different provider groups, business, government and citizens (e.g., the seven district councils.) The participants were not randomly selected. They were either members of groups; recommended by individuals within the Department of Health and Human Services or the Executive Councilors; or selected by the Executive Councilors. The goal was to elicit a range of different perspectives from people actively engaged in the provision, use and purchase of health care.

³In 1993, the New Hampshire legislature engaged in a similar exercise and passed a resolution stating principles upon which a universal health care program in New Hampshire should be based. They are as follows:

1. Universality: all individuals in the state have a right to high quality, comprehensive health care regardless of employment status, health status, gender, age, personal resources, or geographic location.
2. Accessibility: everyone should have equal access to health care providers and to the information necessary to make informed choices.
3. Comprehensiveness: all necessary health care is covered, with an emphasis on preventive care and the promotion of wellness
4. Affordability: health care must be affordable for all individuals in the state. Costs must be distributed equitably, based on ability to pay.
5. Cost Control: there must be cost control and capacity containment.
6. Accountability: individually and collectively, directly and through elected representatives, all individuals must be empowered to influence and improve the health care system continually.

Introduction

Last Revised: 11/12/98

Dynamic Planning For A System In Transition

Guidelines for Change proposes processes and structures that New Hampshire should use to make health planning a continuous initiative and it also allows the State to respond to and manage the rapid changes in the health care environment. It is not a traditional health plan that lays out the number of providers and facilities necessary with a step-by-step process on how to get there.

Massive market changes and the corresponding reactions to those changes are re-aligning, re-structuring and consolidating all that was once familiar in the organization and financing of health care. These forces are driven by regional and national developments that go far beyond the control of State government. Amidst these massive changes in the health care system, traditional health planning has become less useful. No single individual or group can offer a detailed blueprint of the ideal health care system. Change has forced a reconsideration of the nature of health planning, as the organization and delivery of health care services are being recast on what seems like a daily basis.

The changes in the way health care services are delivered are being matched by the changes in the organization of health care providers. The rapid rate of mergers of existing health plans and the equally rapid dissolution and creation of new health care organizations are altering the delivery system. Perhaps the most compelling factor that prevents simply supporting the status quo is that the status quo is rapidly disappearing. The organizational arrangements that held the status quo in place supported a system characterized by independent providers caring for patients who in turn had an unrestricted choice of physician or hospital. The financial arrangements reimbursed care on a fee-for-service basis through employer-based indemnity insurance. These organizational and financial arrangements are rapidly disappearing. The world of national and regional provider systems, constrained consumer choice, capitation and managed care are upon us.

For New Hampshire the question is not how to preserve the past but how to adapt to and direct the changes that are unfolding. How can we assure the system in transition continues to promote improvement in the health status of New Hampshire's citizens? The planning work engaged the citizenry in answering that question.

Citizen Participation in Action

The New Hampshire health care planning work began with the development of health status indicators and goals for New Hampshire's health care system, moved on to detailed discussions on the delivery system, and finally, to summarizing the issues that must be addressed and proposing recommendations.

From the outset of the planning work in the late fall of 1995, a commitment was made to citizen participation and a cautious application of traditional planning techniques. Given the changes in the world of health care, the planning efforts were targeted on:

- **The Requirements.** Instead of dictating how all of the parts should fit together, the health planning focused on the participants' requirements of a system.
- **Honoring the Needs of the State, Communities and the Market.** The question was how best to create a planning system that expressed and balanced the needs and concerns generated from each perspective.
- **Strategic Framework.** The planning focused on a strategic framework for the entire population versus programmatic or categorical recommendations for specific segments of the population.
- **Decentralized Decision-Making.** The community council meetings were held in various regions within the State rather than in Concord. Health care has been always been a local affair, and a broad process for changing the health care system should take place as close as possible to the communities that will be affected by the changes.
- **Inductive Reasoning.** In keeping with the belief in citizen participation and collaboration, the planning relied upon working from the specific and concrete to the general and abstract. Before individuals were asked to recommend general goals for the health care system, they were asked to propose concrete examples of health. These indicators of health included comments such as : "My cancer is in remission." "My child can go to a safe day care center." "My grandfather has transportation to a local senior center."
- **Iterative.** Planning was viewed as a process that should be continuously revised as the health care environment changes. The *New Hampshire Health Plan* would be built upon previous work (e.g., reports and legislative initiatives).

This effort was accomplished through an open and collaborative process that relied heavily upon citizen participation and inter-governmental involvement. The Executive Councilors worked with the Department of Health and Human Services to create seven community councils called District Councils throughout the State with diverse representation of more than 250 citizens. Each of these District Councils defined health care problems and offered many of the solutions included within this report. The District Councils also convened town meetings in which more than 600 New Hampshire residents participated. More than 50 professional and consumer groups were consulted on an ongoing basis. Twenty-two focus groups examined the values that should be preserved in the health care system and the appropriate designation of roles and responsibilities within the State. Representatives from the Governor's Office, the Department of Education, the Department of Insurance, the Department of Environmental Services, and the Attorney General's Office also participated in this effort.

The Office of Planning and Research also relied upon information in the literature on health care reform and on precedents from other States. National health care experts and policy makers from other states were consulted as to what has and has not worked. Some of this information was disseminated through reports and some through a series of symposia on a diverse range of topics. Finally, the analysis and resulting strategies presented in this seventh report were critiqued by panels of state and national experts.

Health Care Planning Accomplishments

This report is based upon a series of reports (which together comprise the *New Hampshire Health Plan*) that were developed through broad public input and discussion. They include:

The Elements of an Ideal Health Care Delivery System. Participants at the first District Council meetings were asked to describe the "ideal health care system". The results of that discussion are summarized in this report.

An Inventory of Health Status Indicators. These indicators can be used to monitor health changes in the general population, the performance of the health care system, the health status of the Department's clients, and the performance of providers caring for the Department's clients. They represent the broad definition of health that encompasses physical, mental, social, and economic well being.

New Hampshire's Health Status Goals. After the Health Status Indicators had been developed, the District Councils established six broad goals to guide its work. Health Status Indicators will be aligned under the Goals and targets will be identified both at the State and community levels - with an eye towards the many determinants of health.

Health Planning, Values and Preferences. This report reviews the responses of 22 focus groups to the questions: "What do you see as essential in any future health care system?" and "What do you find intolerable?"

The State, Communities and Individuals: Roles and Responsibilities in New Hampshire's Health Care System. This report outlines the focus groups' identification of the major functions within the health care system and their assignment of these functions to various sectors within New Hampshire.

New Hampshire Network Survey Report. This report is a review of 29 health and social service networks that have been developed or are in the process of being created in New Hampshire.

Planning and the Health Care System: A Question of Balance. This serves as the resource document. It provides the background information that led to the

recommendations, a survey of the literature on health care reform and its effects on the current delivery system, and precedent from other states. It also includes some data and examples from around the State that illustrate how New Hampshire is responding to the changing health care system.

Consumer Report. In order to inform the general public, a "consumer friendly" version of the seventh report was developed. The reasons for the creation of a Health Plan and key consumer issues are presented in an easy-to-read booklet format.

Many of these reports - including *The New Hampshire Health Care System: Guidelines for Change* - will be accessible through the Department's library at its web site that may be reached through the State of New Hampshire "Webster" site: <http://www.state.nh.us/> by searching under "Executive" for "Health and Human Services" in the "State Agencies on the World Wide Web."

They can also be requested from the NH Department of Health and Human Services, Office of Planning and Research at:

**129 Pleasant Street
Concord, NH 03301
Phone number: (603) 271-5254
FAX number: (603) 271-8431**

Public comments on this report are encouraged, and they may be directed to the above address.

I. New Hampshire's Health Vision, Values and Goals

Last Revised: 11/12/98

A guide for change in the health care system will represent the interests of New Hampshire citizens only if it is built on an accurate assessment of New Hampshire's vision and values regarding health. For this reason, the health planning process began with consideration of the following questions. What is the best way to use and to understand the terms "health" and "health care"? What are the values that New Hampshire citizens hold most important regarding the health care system?

The Definition of "Health"

The participants in the Health Care Planning Process and the Department of Health and Human Services decided that any consideration of the health care system should be based on a positive definition of the terms "health" and "health care." Health is not merely the absence of illness; it is the presence of well-being or the realization of potential. Health care should not be understood merely as treatment for illness; it should include necessary and appropriate services, medical, social or other, that is intended to promote the highest possible level of function and independence for an individual. Health care should address the whole person. Its goal should include physical, emotional and spiritual growth, satisfaction and fulfillment - the flourishing of the individual.

For these reasons, the term "health," as used herein, will have the same definition as that put forth by the World Health Organization:

"A state of complete well-being, physical, social and mental, and not merely the absence of disease or infirmity."

Correspondingly, the term "health care," will mean:

"Services, medical, social or other, the primary purpose of which is to promote the highest possible level of function and independence for an individual."

Vision

In order to ensure that New Hampshire residents enjoy the highest quality of life attainable, the *New Hampshire Health Plan* will promote access for everyone to necessary and appropriate health and social services.

Health System Values

In order to find out what values New Hampshire citizens held most important regarding the health care system, the Office of Planning and Research used two sources. The first

and most significant source was the extensive set of discussion groups that were conducted throughout the State.¹ The second source was derived from work conducted by the seven District Councils. The participants in each District Council were asked to discuss and agree upon a set of statements describing the functional characteristics of an ideal health care delivery system by answering the question: What would an ideal health care delivery system do?

The purpose was to elicit the expression of core values that could be used to set requirements for the health care system in the future.² As part of this endeavor, two questions were presented to the discussion groups:

- What do you consider to be essential in any health care system?
- What do you consider to be intolerable?

The five core values common to both of these sources are listed in Table 1 and described following the table.

Table 1

New Hampshire Health System Values	
1.	Every New Hampshire citizen will have access to necessary health care services regardless of individual circumstances.
2.	The health care system will be based on desired health outcomes as determined by well-defined indicators for measuring health.
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4.	Health care consumers will be empowered and assume primary responsibility for their health and for the care they receive.
5.	Communities will play a role in the organization and integration of health systems and in the delivery of health care services.

1. Every New Hampshire citizen will have access to *necessary* health care services regardless of individual circumstance.

Access to care should not depend on ability to pay, employment status, age, gender, geographic location, or any factor other than a determination of individual need. This means, in part, that services must be affordable to everyone. Affordability, in this sense, means using subsidies to adjust payment for care (either premiums or direct contributions for care) based on income.

Universal access requires, among other things, the existence of a basic or standard benefit package that is available and (through targeted subsidies) affordable to everyone and that is sufficiently comprehensive to cover all necessary care. The basic or standard package may need to be customized for the populations that are being served (e.g., children need a different set of services than adults and persons with disabilities often have special needs for medical equipment and pharmaceuticals).

Universal access to necessary care is not simply a matter of insurance coverage, even if such coverage is adjusted to the special needs of different populations. Needed services must be available as well as affordable, particularly for persons in rural areas and some underserved urban areas and for those with long term or high cost needs. Access exists only when an appropriate mix of providers is present in the community. This includes providers of non-medical, health related services, such as respite services³ or transportation assistance, that address the needs of the individual and the family. Some services are not (at least at this stage of the health care system's development) amenable to managed care or the operation of the insurance marketplace. Assuring the availability and affordability of such services is a matter of assuring the existence of a safety net of community-based social service and health care providers.

2. The health care system will be based on desired health *outcomes* as determined by well-defined indicators for measuring health.

The transition from understanding of health care as essentially treating illness to health care as promoting well-being leads to an increased emphasis on health outcomes. The health care system should be evaluated and shaped on the basis of desired health outcomes.⁴ Health Status Indicators and Health Status Goals should play an important role in developing guidelines for change in the health care system (see pages 14-16). This means an increased emphasis should be placed on prevention and wellness. Currently, many care systems are illness-oriented and focused solely on the delivery of medical services. By making better use of public health expertise, by restructuring incentives to providers, insurers, payers and consumers, and by adjusting the criteria for allocating resources, the health care system could be designed to promote desired health outcomes as determined by well-defined indicators for measuring health.

3. The health care system will emphasize *quality of care* and focus on *controlling costs*.

In the rapidly evolving and increasingly bottom-line oriented health care system, there should be greater emphasis on preserving and assuring adequate quality of care. Managed care should be monitored and incentives used to ensure that it promotes the best care and not just the best price. If managed care case managers are able to limit choice of provider or services, they should be subject to the same quality of care standards as are health care providers. Case management should not be carried out in such a way as to harm the therapeutic relationship between the provider and the patient. With the advent of managed care, the degree to which health care services are consumer sensitive and consumer responsive ought to increase rather than decrease.

The member of a health plan must play a prominent role in assessing and improving the quality of care. Consumers should have access to improved processes for seeking resolution to problems. Consumer satisfaction and functional⁵ outcomes should receive equal weight with evaluations of technical competency and clinical procedures. Patients must be treated with dignity and respect and in a manner that is sensitive to cultural and socioeconomic differences. Consumers should be given a more active role in improving the quality of services by allowing them to articulate an assessment of the care they received (or did not receive as promised in their contract) and holding providers and insurers accountable to respond to that assessment.

4. Health care consumers will be *empowered* and assume primary *responsibility* for their health and for the care they receive.

Consumers should have sufficient information to exercise informed choice regarding their own health. Choice, in this context, is defined as the ability to choose (or retain) a provider as well as the exercise of personal autonomy - i.e., the ability to control what services one receives.

Consumers need improved information and education in order to make the exercise of choice meaningful, to promote individual responsibility, and to improve the quality of care. The quality of the lives of citizens could be improved if they had better information and training about the impact of their behavior on their lives (smoking, drinking, diet, exercise, drugs, risky sexual behavior, etc.) and better guidance and assistance for self-help. In addition, the system could be used more wisely and consumers would be better informed if they knew how to assess the quality of providers or health plans that were in their community (e.g., if "report cards" existed that compared health plans or providers on similar quality standards). Consumers would also have a much better experience with the health care system if they understood how the system should be used, what the provider responsibilities are and what the patient's responsibilities are. This is an essential step in promoting individual responsibility.

The individual also plays an important role in improving the viability of the current market-based approach to managing costs. Individuals should have better access to information about the cost of their health care decisions. All individuals should pay something towards the cost of their care, if only a small amount.⁶

5. *Communities* will play a role in the organization and integration of health systems and in the delivery of health care services.

The term "communities" can be defined in two ways: as a group of residents in a specific geographic area with distinct regional characteristics, and as groups of individuals (usually statewide) who have, or are relatives of individuals who have, specific physical or mental conditions. In either case, communities should play a strong role in identifying community needs and ensuring access.

Market-based solutions should not be pursued at the expense of communities. Community needs and preferences should be built into market solutions. The increasing consolidation of the market (e.g., such as the merger of two health plans) should not result in the neglect of the needs of individual communities. (Some participants in the Health Care Planning Process wanted community-based institutions and providers with a historical commitment of service to a locality to be given preference to competitors from outside the area.) Finally, cooperative solutions developed by consumers and local providers should be preserved and protected - e.g., the community care system for persons with developmental disabilities.

Communities are also essential to the task of improving the integration and coordination of care. Savings could accrue if the duplication of efforts among providers could be reduced and the coordination of care within and between medical, mental health and non-medical health-related service providers could be increased. Administrative costs could be reduced, particularly if there was a streamlining of programmatic requirements from state and federal government. This integration and coordination must take place primarily at the community level. This is particularly true with long term care and services for the chronically ill, where there is a need to integrate a diverse set of community resources to support individuals and families in the community with a continuum of care.

This emphasis on community should be tempered by the fact that health care decisions must remain personal decisions. Not all localities have the expertise to make policy decisions about health care and some participants feared that communities might punish unpopular members.

While not an explicitly stated value, a common theme that ran through the planning work and strategy development was that the effort to control health care costs through private markets should be informed by consideration of the limits of markets.

The cost of health care is a barrier that needs to be overcome in order to achieve universal access to care. The theoretical assumption behind the current trend toward mergers, networks and managed care is that the cost barrier can be overcome through a market-based approach. However, the market, especially in the context of health care, is not a panacea.

First, a purely market-based approach to health care would never reach universal access. Markets ration by the ability of individuals to pay for goods and services, and there will always be many individuals who cannot afford to pay for the health care that they need. It is not appropriate to ration health care based on ability to pay. Second, steps need to be taken to improve the operation of the health care market before there can be an effective market solution. For example, consumers and purchasers must be empowered with information and choice in order to create meaningful competition based on the value of the services provided. Similarly, incentives to providers, insurers, purchasers and consumers need to be structured to promote cost effective practices and systems and to maintain an appropriate balance between investment in high-tech care and providing for basic health needs. Third, a market-based solution may never be appropriate for some

populations with special needs. Finally, community needs, community-based institutions and providers, and community-based cooperative solutions should be considered with market solutions.

Generally, it is the role of the state to monitor the health care market and to ensure that it operates in a manner that is consistent with the interests of consumers. In this regard, the State should make a special effort to streamline and standardize regulatory requirements and information systems to eliminate duplication.

Health Goals

After an extensive discussion of the definition of health and the indicators by which health status ought to be measured, the members of the District Councils were asked to articulate a vision and goals statement for the health status of New Hampshire citizens. The result was the following statement.

New Hampshire Health Status Vision and Goals

To ensure that New Hampshire residents will enjoy the highest quality of life attainable, **the New Hampshire Health Care Plan will promote universal access to necessary and appropriate health and social services.** The Health Care Plan will be a strategy for achieving the Health Status Goals (see Table 2). The Health Status Indicators that are associated with the goals will provide benchmarks for measuring New Hampshire's progress in achieving health and well-being. The Plan, the Goals, and the Indicators will be developed with input from hundreds of New Hampshire citizens.

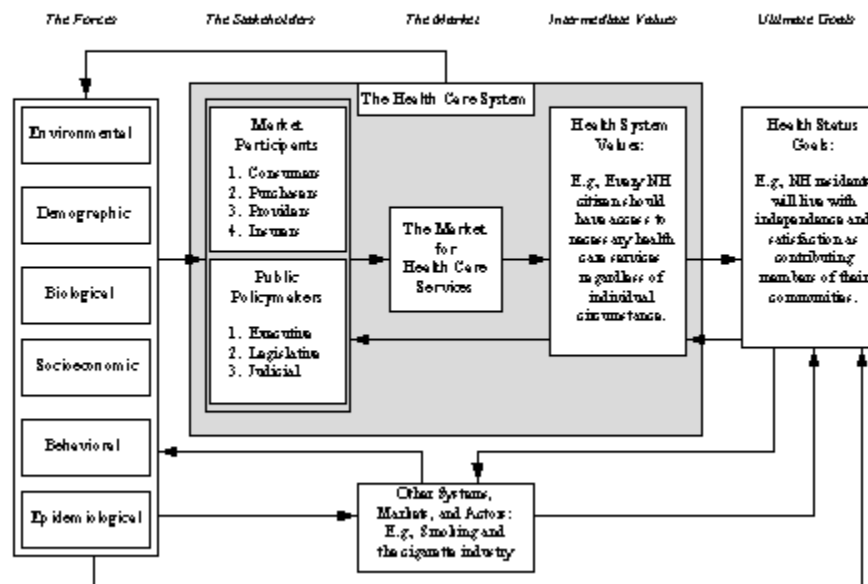
Table 2

Health Status Goals

- 1. New Hampshire residents will live with independence and satisfaction as contributing members of their communities.**
- 2. New Hampshire residents will live with a minimum of disease and disability.**
- 3. New Hampshire residents will live in safe and supportive homes and communities.**
- 4. New Hampshire residents will live free of environmental hazards.**
- 5. New Hampshire residents will have the educational and economic opportunities they need to realize their full potential.**
- 6. New Hampshire residents will choose behaviors which contribute to health and well-being.**

The definition of "health" adopted for the health planning work describes a state of complete physical, mental, and social well-being. The supporting *Health Status Goals* address a broad array of factors affecting the quality of life in New Hampshire. It becomes clear that the health status of the population or of an individual is only partially determined by what we traditionally think of as the health care system - the sum total of all people, institutions, relationships, laws, regulations, customs and practices involved in the financing and delivery of health care. Factors such as the physical environment, education, income, and lifestyle are more determinative of health status than the health care system. A more complete perspective on the impact of the health care system and other forces on health status is suggested in Figure 1.⁷

Figure 1 Health-Related Forces and the Health Care System



Health is influenced in the first instance by environmental, demographic, socioeconomic, behavioral, cultural, and epidemiological forces. Many of these forces affect a society's health in ways that are largely independent of the health care system. One example is the expanding elderly population. Although the health care system may respond to this demographic change by developing new approaches to health care that address the special needs of this group, it is not likely that the system will be able to prevent an overall increase in the incidence of age-related illness. The effects of these forces will also depend on the responses of other systems, markets and other players that are not directly involved in the health care system. For example, cigarette manufacturers may opt to conceal information about the harmful effects of smoking and promote smoking among young persons as a behavioral norm with disastrous consequences for the public health.

It is clear that even if the health system values described above were completely actualized, this would not be sufficient to ensure the fulfillment of the health status goals. The health system values are merely intermediate values and not ends in themselves. They are valued as means for the efficient and equitable promotion of the ultimate goals for health status.

For these reasons, a comprehensive plan for achieving the health status goals should address a broad range of values and recommendations involving every system, institution, market, or player that is significantly related to any of the forces affecting health status.

Taking the Measure of New Hampshire's Health

The New Hampshire health care planning work began in the late fall of 1995 with the development of the *Health Status Indicator Inventory*. Hundreds of consumers, health and social services providers, advocates and officials from 40 states were interviewed. Before individuals were asked to recommend general goals for the health care system, they were asked to propose concrete examples of health. From the outset, people defined health broadly and did not think solely in terms of medical care.

The initial draft of the *Health Status Indicator Inventory* was reviewed by most of the contributors, plus units within the Department of Health and Social Services, the District Councils and anyone else who requested a copy. Additional revisions were made with particular attention to selected populations (e.g., substance abusers, elders, developmentally disabled and others). While the *Health Status Indicator Inventory* was being revised, the District Councils assisted the Department in developing *New Hampshire's Health Status Goals* (that were listed above). Next, the District Council members used the *Health Status Indicator Inventory* to identify the areas that should be included under each *Health Status Goal*. The *Inventory* contains 284 indicators; the goals and their indicator areas are listed below.

1. New Hampshire residents will live with independence and satisfaction as contributing members of their communities.

- | | |
|--|-----------------------------------|
| ▪ Ability for self-determined treatment and management | ▪ Community participation |
| ▪ Transportation | ▪ Reported sense of well-being |
| ▪ Child care | ▪ Level of insurance |
| ▪ Housing tenure or ownership | ▪ Employment rate |
| ▪ Respite care | ▪ Attendant care |
| | ▪ Access/availability of services |
| | ▪ Independent skills instruction |

2. New Hampshire residents will live with a minimum of disease and disability.

- Immunization rates
- Cancer incidence
- Death rates
- Prevalence of disability
- Arthritis, diabetes
- Days lost from work
- Dental health
- Prevalence of mental illness
- Prenatal care
- Neonatal health
- Infectious disease
- Primary care access
- Behavioral health access
- Substance abuse and alcohol
- Chronic disease incidence
- Disease outbreaks
- Prevention services

3. New Hampshire residents will live in safe and supportive homes and communities.

- Violence and abuse; domestic assault
- School drop-outs
- Crime rate
- Exploitation and neglect
- Teen birth rate
- Adequate housing
- Unintentional injuries
- Accessible public facilities
- Placement outside community
- Children who move during the school year
- Homelessness
- Divorce rate
- Child support enforcement
- Senior fraud

4. New Hampshire residents will live free of environmental hazards.

- Clean air
- Fluoride
- Lead
- Clean water
- Occupational hazards
- Workplace injuries
- Disposal of toxic waste
- Asbestos
- Safe food
- Noise

5. New Hampshire residents will have the educational and economic opportunities they need to realize their full potential.

- Special education
- Level of education
- Enrichment activities
- Employment rate
- Income levels
- Job availability
- Job training opportunities
- School drop-out
- Early childhood development
- Job satisfaction
- Scholarship/financial assistance
- Adult education
- Employee/family benefits

6. New Hampshire residents will choose behaviors which contribute to health and well-being.

- Smoking
- Seatbelts
- Substance abuse
- HIV/STDs
- Physical fitness
- Nutrition
- Helmet use
- DWI
- Auto crash rates
- Water safety
- Teen birth rate
- Handguns
- School health education

As a continuation of the health planning work, the Department will develop public-private partnerships to consider three issues:

- Which indicators should be included among the "key" indicators (a short list of important indicators)?
- What strategies would permit and foster the development of readily available data for the health status indicators?
- What strategies can be employed to collect data that is not presently available?

The Health Care System

The following strategies for State⁸ action focus primarily on the medical services component of the health care system. There are a number of reasons for this approach at this stage of the development of the *New Hampshire Health Plan*.

The health care system continues to evolve rapidly in response to both private and public initiatives.⁹ Mergers and alliances among providers, insurers, and purchasers are occurring at a breathtaking pace.¹⁰ The Medicare and Medicaid programs are moving toward privatization, and health insurance reforms continue to be the frequent subject of legislation on both the state and national levels. In this environment, it is prudent to focus health planning resources on identifying goals and guidelines that can be used to manage this rapid change.

There is a practical advantage to focusing initially on the health care system in that its effects on health status are more immediate. Although factors such as education and income appear to have much larger effects on health status than does access to health care,¹¹ the benefits of an investment in heart surgery, for example, are immediate and measurable, while the benefits of a similar investment in college scholarships for low-income youths would be difficult to measure.¹² Even though the aggregate health benefits to society of the latter might be larger, they would be more difficult to isolate and to justify the investment.

Considerations of equity and social justice also tend to focus attention on the health care system. Many participants in the Health Care Planning Process felt that the current health care system fails badly on this scale. For New Hampshire's uninsured citizens, it fails to fulfill the first health value - that every New Hampshire citizen should have access to necessary health care services regardless of ability to pay.

Other components of the health care system (as defined on page 13) are addressed in :

- determination of a health insurance benefit package (recommendation 3).
- determination of the scope, funding sources and providers of safety net services (recommendation 7).
- promotion and support of health-related non-medical services (recommendation 8).
- determination of research topics (recommendation 24).
- innovation in the delivery of health and social services (recommendation 25).

II. Strategies For State Action

Last Revised: 11/12/98

Among most of the 1,000 citizens who participated in the different health planning forums, the proper response of the State was often discussed in terms of different and often competing roles and responsibilities with communities and the private market. Most citizens expressed the need for a balance between the State, communities and the market. Each had strengths and weaknesses. No one viewed any approach as always preferable to the others. If there was any common perspective across discussants it was that the State's role should be minimized and that as many functions as possible be assumed by communities and the private sector.

A majority of individuals suggested that the State should be responsible for two major goals:

- promoting the health status and well being of its citizens.
- assuring that needed health care goods and services be available to all New Hampshire residents regardless of their ability to pay.

The changes in the health care system required a review by the State of the policies and procedures that it will keep, those that it would eliminate and those it will change. The health planning work assisted this review. District Council members and other planning participants identified functions that they believed were or should have been within the jurisdiction of the State:¹³

- The design and application of health benefits.
- The financing of health benefits.
- Assuring the quality of care.
- Assuring the fiscal solvency of risk bearing entities.
- Mediation.
- Development of an information infrastructure.
- Monitoring and supporting communities.
- Monitoring and supporting markets.

The roles envisioned for the communities were not as extensive as those seen for the State. No one felt that any existing agency or organization could represent all of the health and social service interests at the local level. However, a number of individuals believed that entities were forming or could be formed that would allow communities to

act as a partner with the State on all state-funded programs; to participate in market solutions; and control local markets for certain populations.

The functions that were identified as being within State jurisdiction are addressed in the four primary strategies outlined in this section:

- promoting access to health care coverage while controlling costs;
- protecting and empowering consumers;
- re-defining public health; and
- partnering with communities.

There are a total of 27 recommendations for implementing these strategies. Each recommendation has a brief explanation, e.g., monitor the number of uninsured in order to assess the impact of market and legislative actions. Some of the recommendations can be prioritized and achieved under existing administrative authority. Others will require legislative deliberation and action.

The following index of the recommendations is presented to guide the reader to areas of specific interest. An index is also included as Appendix C.

A. Promoting Access To Health Coverage While Controlling Costs

Recommendation 1. The Department of Health and Human Services, the Department of Insurance and the Office of the Attorney General, together with market participants, should jointly monitor and respond to market behavior.

Recommendation 2. Monitor the uninsured and underinsured to track the effectiveness of the changing market in addressing their needs.

Recommendation 3. Consider establishing a standardized set of benefit packages for the health insurance market.

Recommendation 4. Consider establishing a risk adjustment system for the health insurance market.

Recommendation 5. Establish a statewide health insurance purchasing alliance for small employers and for individuals.

Recommendation 6. Provide a subsidy for the purchase of private insurance coverage for those who are uninsured because they cannot afford it.

Recommendation 7. Determine the scope of "safety net" services that should be available, the necessary level and sources of funding to maintain these services, and who should provide the services.

Recommendation 8. Support and promote systems that coordinate health-related non-medical services with medical care to improve outcomes.

Recommendation 9. Revise the role of Certificate of Need to keep pace with the rapidly changing health care market. (Page 42)

Recommendation 10. Work with communities, market and provider representatives to establish both minimum standards of adequacy for the delivery system and a process and incentives for encouraging providers to practice within medical shortage areas or areas that do not meet minimum standards of adequacy. (Page 44)

B. Protecting And Empowering Consumers

Recommendation 11. Establish an independent mediator, with the authority to make recommendations, for disputes arising among consumers, providers, health insurers and managed care organizations. (Page 48)

Recommendation 12. Create an independent consumer hotline for complaints regarding health insurance coverage. (Page 48)

Recommendation 13. Promote and participate in an organization which would develop innovative quality monitoring and improvement activities. (Page 50)

Recommendation 14. Develop a coordinated monitoring policy for all health care services for which there is current State Legislative or regulatory authority. (Page 51)

Recommendation 15. Develop the capacity to provide data that allows citizens to review the health status of communities and the statewide population; to understand the performance of State and market functions; and to understand the status of community concerns. (Page 53)

Recommendation 16. Promote the private development of information that helps improve the health status of New Hampshire citizens and the operation of the health care system. (Page 54)

Recommendation 17. Establish licensure for health care organizations that bear financial risk based on a formula that adjusts capital and reserve requirements to the number of covered lives served by an organization, its structure, and the percent of risk that the organization will assume. (Page 56)

Recommendation 18. Develop guidelines governing the transfer of financial risk from one entity to another. (Page 57)

Recommendation 19. Establish the capacity to track the number of self-insured plans, require such plans to disclose to their enrollees that they are self-insured, and provide support and guidance to individuals insured under such plans. (Page 58)

C. Re-Defining Public Health

Recommendation 20. Collaborate with the Turning Point Steering Committee to reassess the functions of public health. (Page 61)

Recommendation 21. Determine whether current baseline monitoring efforts are adequate or should be expanded to monitor health risks and outbreaks. (Page 62)

Recommendation 22. Implement improved coordination of health promotion and wellness activities across government agencies, managed care and other organizations. (page 63)

Recommendation 23. Determine the level of support which the State and private entities (such as managed care organizations) ought to provide to public and private health care provider training programs. (Page 64)

Recommendation 24. Determine the critical areas for public health and public research and establish criteria for public and private funding. (Page 65)

D. Partnering With Communities

Recommendation 25. Maintain and protect the Health Care Transition Fund to support innovations in the delivery of health and social services. (Page 72)

Recommendation 26. Retain the District Councils as a permanent part of health planning and policy development. (Page 75)

Recommendation 27. Develop operational standards for community benefits, with representatives from communities, non-profit providers, and representatives from the Department of Insurance and the Office of the Attorney General, that reflect community values. (Page 76)

¹ Twenty-two discussion groups served as proxies for the State's citizens. The groups ranged in size from 6 to 40 members. Some of these groups consisted of individuals with similar backgrounds or concerns (e.g., hospital administrators or individuals with disabilities) or mixed gatherings of citizens representing the concerns of different provider groups, business, government and citizens (e.g., the seven district councils.) The participants were not randomly selected. They were either members of groups; recommended by individuals within the Department of Health and Human Services or the Executive Counselors; or selected

by the Executive Counselors. The goal was to elicit a range of different perspectives from people actively engaged in the provision, use and purchase of health care.

² In 1993, the New Hampshire legislature engaged in a similar exercise and passed a resolution stating principles upon which a universal health care program in New Hampshire should be based. They are as follows:

1. Universality: all individuals in the state have a right to high quality, comprehensive health care regardless of employment status, health status, gender, age, personal resources, or geographic location
2. Accessibility: everyone should have equal access to health care providers and to the information necessary to make informed choices.
3. Comprehensiveness: all necessary health care is covered, with an emphasis on preventive care and the promotion of wellness.
4. Affordability: health care must be affordable for all individuals in the state. Costs must be distributed equitably, based on ability to pay.
5. Cost Control: there must be cost control and capacity containment.
6. Accountability: individually and collectively, directly and through elected representatives, all individuals must be empowered to influence and improve the health care system continually.

³ Respite services are when professional care is provided in place of family care for an individual living at home; it might consist of placement in an institution or paid help at home.

⁴ Health outcomes refers to the patient health status and satisfaction resulting from specific medical and health interventions.

⁵ Functional outcomes refers to the ability to perform regular activities of daily living.

⁶ For very low income persons, however, the contribution must be truly nominal in order to prevent it from acting as a barrier to needed care. Even a five or ten dollar copayment can be a barrier to needed care for the very poor.

⁷ This figure is adapted from a model proposed by J.D. Wilkerson, K.J. Devers, and R.S. Given in *Competitive Managed Care: The Emerging Health Care System*. San Francisco, CA, Jossey-Bass Publishers, 1997, p. 361.

⁸ Throughout this report references to the State refer to the Executive, Legislative and Judicial branches of government (this also includes the recommendation of the stakeholders advising the State, implementing strategies and designing new solutions).

⁹ Ginsberg, P. "A World in Transition." *Business and Health*, April 1996, pp. 60-62.

¹⁰ Solomon, J. "With or Without You." *Newsweek*, Aug. 15, 1994, pp. 58-59.

¹¹ Fuchs, V.R. *The Future of Health Policy*. Cambridge, MA, Harvard University Press, 1994.

¹² J.D. Wilkerson, K.J. Devers, and R.S. Given in *Competitive Managed Care: The Emerging Health Care System*. San Francisco, CA: Jossey-Bass Publishers, 1997, p. 359

¹³ See *The State, Communities and Individuals: Roles and Responsibilities in New Hampshire's Health Care System*, NH DHHS, Concord, NH, February, 1997 for a detailed discussion of this topic.

II. Strategies for State Action:

A. Promoting Access To Health Care Coverage While Controlling Costs

Last Revised: 11/12/98

New Hampshire continues to enjoy the benefits of a strong economy and is among the nation's leading states in terms of the overall health of its residents. Despite this good news, New Hampshire's health insurance market still leaves an alarming number of people without health insurance coverage at considerable cost to the State's health care system in terms of uncompensated care and health insurance premiums. According to a December 1997 study commissioned by the New Hampshire Insurance Department, 10.9% of New Hampshire's 1.2 million residents were without health insurance in 1996 approximately 130,000 persons.

A Coordinated, Multifaceted Reform Strategy

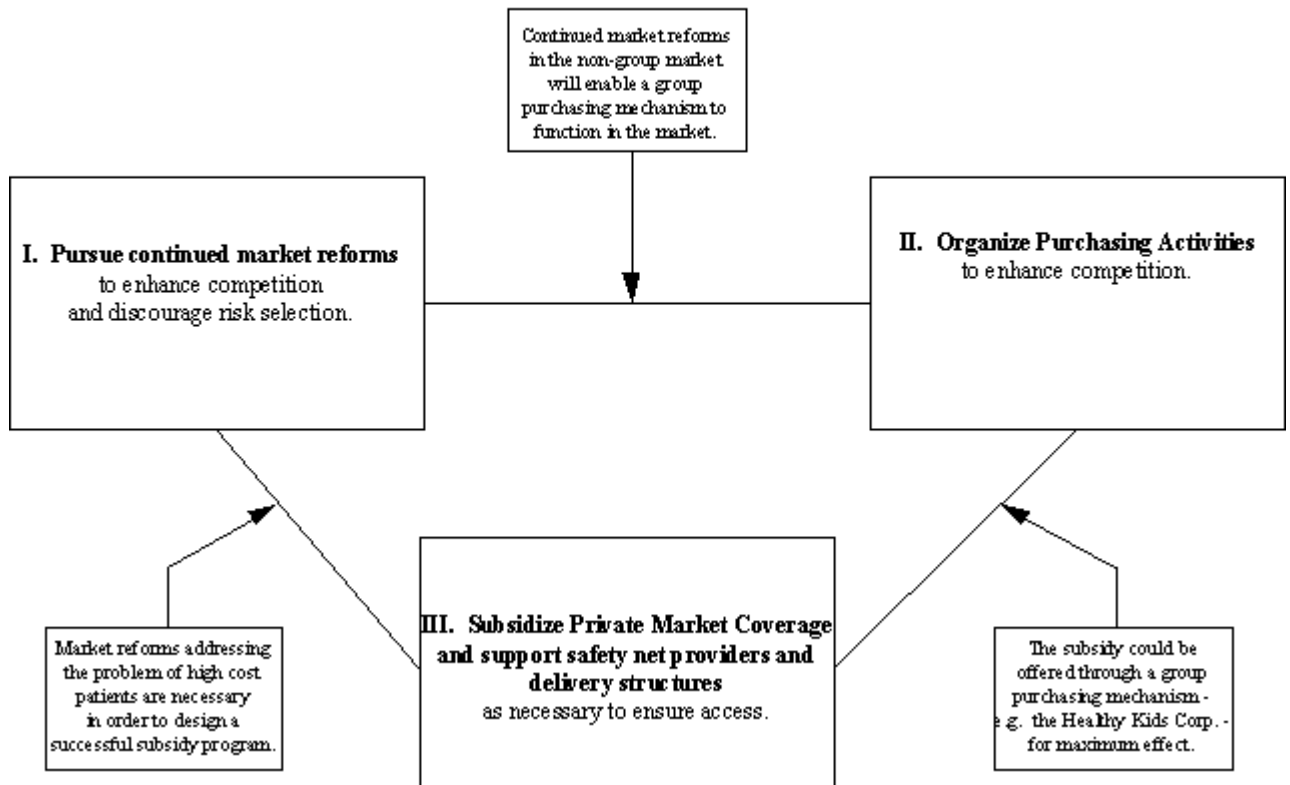
The challenge in addressing the problem of the uninsured through a voluntary approach is to coordinate the effort with other health reforms so as to avoid expending resources on initiatives that fail to eliminate the root of the problem or that merely shift the problem from one area to another. The strategies and initiatives outlined here are designed to improve access to health insurance coverage and control costs through incremental reforms that address all aspects of the health insurance market and that are coordinated to achieve maximum combined effect.

The core strategy is three-fold:

1. pursue continued insurance market reforms to enhance competition and discourage risk selection;
2. organize purchasing activities to enhance competition; and
3. subsidize private market coverage and support safety net providers and delivery structures.

Figure 2 provides a pictorial depiction of this approach. A number of synergistic effects are achievable through a coordinated approach. For example, in order to maximize the effect of providing a subsidy for insurance coverage, it might be advisable to provide the subsidy through a group purchasing mechanism (such as a purchasing alliance or existing employer coverage). Similarly, any comprehensive program to provide a subsidy for insurance coverage must be accompanied by a regulatory effort to address the problem of financing coverage for high cost patients. If insurance carriers are allowed to shift high cost patients to the subsidy program, the program could become financially insupportable.

Figure 2
Promoting Access to Health Coverage While Controlling Costs



Most participants in the health planning work felt that the State should adopt as a priority the goal of universal health care coverage for New Hampshire's citizens. As used in this context, "universal coverage" means that 100% of the residents of the State have coverage. Most planning participants also felt that coverage expansion should be based on voluntary participation by individuals and employers. It is important to note that voluntary participation and universal coverage are not completely compatible goals. This is because voluntary participation means that there can always be a group of individuals and employers who can afford to purchase health coverage but do not. If that is the case, universal coverage can be a goal but it may not be achieved in a voluntary system. No country that has achieved universal coverage has been able to do it without mandatory participation (no one can choose not to be covered), mandatory financial contributions, and government controls over total expenditures.

What is more achievable in a voluntary system is what we might call "universal coverage availability." Universal coverage availability exists when all persons wishing to have coverage do in fact have it. The following recommendations developed from the health planning work are designed to promote universal coverage by way of universal coverage availability. This approach recognizes that expansion of coverage must be incremental and is dependent upon the funds that are available as well as the existence of sufficient political and popular support.

1. Pursue continued insurance market reforms to enhance competition and discourage risk selection.

Many advocates for health care reform have proposed that only competition and private markets will be capable of controlling costs, ensuring access, and maintaining quality of care. However, a market solution is viable only when there is a sufficient level of market competition. The market benefits derived from pure competition (minimum costs, maximum efficiency, high quality of care) do not necessarily accrue in the current health care environment. For markets to maximize benefits, there must be a large number of buyers and sellers, a uniform product, minimum barriers to entering the market, and complete information availability on the cost and quality of the services being sold. These conditions are not present in the health care market. The barriers to competition in the health care market which must be addressed if a market-based approach is to succeed are as follows:

- Consumers and purchasers have inadequate information about the cost, quality and effectiveness of the services being purchased.
- Consumer choice is limited.
- Consumers of services are often not the buyers of services.
- Health benefit plans are not readily comparable to another.
- There are incentives in the health insurance market that are unrelated to efficiency or value, most importantly, the strong incentive to minimize costs by avoiding high cost individuals.
- Due to market consolidation, some health insurers and providers approach monopoly¹⁴ or oligopoly¹⁵ power.

The State cannot and should not attempt to create perfect competition in health care. The public policy goal is to determine when the imperfections are acceptable and serving the best interests of the citizens of New Hampshire, and when they are not. The market should be subject to empirical tests. If it works, the State should refrain from being involved. When the system is not working, the State should intervene or assist the market. Market participants are key to developing those standards by which market performance would be assessed. This section explores interventions that are likely to promote this latter goal.

Interagency Coordination of Market-Related Functions

Recommendation 1. The Department of Health and Human Services, the Department of Insurance and the Office of the Attorney General, together with market participants, should jointly monitor and respond to market behavior.

When economists discuss the market in health care they either dismiss its application because the health care system fails to meet the definition of a pure market or they dismiss the imperfections as unimportant compared to the power and effectiveness of market forces. In either case economists have failed to operationally define, in economic terms, when the imperfect health care market is working well and when it is not. If markets are to be used to solve problems that have broad social and political implications, then there must be operational standards that indicate when the State and communities should intervene in the public interest and when they should refrain from disturbing market behavior.

In order to support the proper development of market reform, the various state agencies involved in the regulation of market behavior should jointly set standards for the proper functioning of the health care market. There are three State agencies whose mission directly concerns the status of the health care market: the Department of Health and Human Services, the Department of Insurance and the Office of the Attorney General. A coordinated approach to improving competition in the health care market and protecting the public interest requires the concerted effort of these agencies.

This coordination can be achieved through the vehicle of an inter-agency agreement. This agreement should address the following functions:

- development of standards for when the market is performing well and guidance for when the market is performing poorly and require State intervention;
- assessment of current market conditions by comparing the performance of different sellers (the insurance companies, health plans and providers), buyers (self-insured individuals, private employers and government), and consumers;
- collection, analysis and distribution of information that will aid in monitoring market behavior and in making decisions regarding market interventions; and
- establishment of a cooperative framework for monitoring and prosecuting anti-trust violations, enforcing community benefit obligations, promoting competition, subsidizing the purchase of coverage to ensure affordability for all, regulating managed care, and for licensing risk-bearing health care organizations.

A Public Health Perspective

Recommendation 2. Monitor the uninsured and underinsured to track the effectiveness of the changing market in addressing their needs.

Markets are designed to serve those who have money and income as efficiently and effectively as possible. Markets work within the existing distribution of wealth. If you cannot afford a good or service, markets will be unresponsive to your needs. That is the nature of markets. From the perspective of promoting the health goals, it is important to examine the impact of markets on the entire population including those who cannot afford to make purchases in the health care market.

In order to track the effects of the changing market on the health status of the population, the State should also track the effect, if any, those changes impose on those who cannot participate in the market. Resources should be committed to improve the capacity of the State to collect and accurately analyze this data. New Hampshire should sponsor an annual survey on the health care coverage of its citizens.

The ability of the state to accurately define, assess, and analyze the scope of the problem of the uninsured in New Hampshire has a direct bearing on the development and success of public and public-private partnerships to expand coverage to the uninsured and improve the health status of the people of New Hampshire.

Standardized Benefits

Recommendation 3. Consider establishing a standardized set of benefit packages for the health insurance market.

There are three interrelated structural problems in the insurance market relative to health benefit design, namely:

- **The difficulty buyers have in doing comparison shopping.** This is a particular problem for purchasing coverage in the individual and small group insurance market. Small purchasers must choose among different policies and plans that have different and often obscure benefits and coverage limitations.
- **The seller's ability to fragment the market and avoid expensive patients through benefit design.** If vendors exclude particular kinds of specialized care or coverage for certain prescriptions, they also reduce the likelihood that people needing that care or that drug will purchase that health plan. On the other hand by offering services that a healthy patient would find attractive - e.g., membership in a health club - the plan can attract a disproportionate number of individuals with a low risk of being ill.
- **The problems encountered in trying to evaluate the quality between different benefit packages and health plans.** When benefit packages vary across all plans, the differences in health outcomes or other quality measures may be attributable to differences in benefit coverage and not necessarily the quality of care.

One approach to these problems is to encourage health insurers to offer a standardized set of benefit packages. All covered persons would be able to choose among a number of different benefit packages designed by the State in consultation with insurers. Consideration should be given to whether these will be the only benefit packages that can be offered by insurance companies and health plans. Establishing a set of standard benefit packages can be effective in addressing problems of comparison shopping, fragmentation of the market and quality while preserving choice of benefits.

Risk Adjustment

Recommendation 4. Consider establishing a risk adjustment system for the health insurance market.¹⁶

Under fee-for-service, a high cost patient with indemnity insurance was a source of revenue. Every time a service was rendered, the provider was paid. In the emerging health care system, those incentives are reversed. HMOs and other risk bearing entities are now often paid on a capitated basis - they receive a fixed price per enrollee per month for all of the services that person may need. Sometimes it is not only the health plan that is capitated. Many of these plans also pay hospitals, physicians and other providers on a capitated basis.

Capitation places a premium on healthy patients (the providers receive their fixed price for each of these enrollees but incur little or no costs caring for these individuals) and creates an aversion to sick patients (whose costs greatly exceed the revenue they generate). If the population is ranked by use of service, the top one percent of the population account for 30 percent of the health care expenditures, the bottom 50 percent of the population for 3 percent of the expenditures. In the individual market in New Hampshire, the situation is even more acute. The most expensive 1.5% account for 54% of all health expenditures in that market.¹⁷ It is far easier for an HMO to make money by avoiding expensive patients - a process referred to as *risk selection* - than it is to be efficient or effective.

Some of this risk selection is the result of consumer choice - healthy patients that make little use of the health care system will choose a less expensive plan. Some of this biased selection is the result of how managed care organizations structure their benefits (restricted access to specialists may discourage sick patients from enrolling); market their services (managed care organizations frequently promote membership in health clubs in marketing campaigns - a service clearly more attractive to healthier patients); or enroll and disenroll patients.

Risk selection has long been recognized as an imperfection in the health insurance market. When a delivery system consists of a mix of capitated managed care plans and fee-for-service plans, risk selection can actually increase the total amount of money spent on health care. This occurs because managed care organizations often price the cost of their coverage at rates that are slightly less than fee-for-service insurance coverage. If managed care organizations can attract a healthier population than fee-for-service, then a greater percentage of those remaining in the fee-for-service system will be infirm, and the fee-for-service rates will increase. The result is "... a small amount of biased selection, well within the range of current research evidence, is enough to increase total costs."¹⁸

This problem persists even when the delivery system consists of only managed care organizations. Risk selection means that some plans - those that are more proficient at enrolling and keeping healthy patients and avoiding or getting rid of unhealthy patients -

will reap considerable profits that are unrelated to their performance. Other plans that conscientiously deliver efficient and effective care to very sick patients will lose money.

Risk selection and risk segmentation in the market are phenomena that threaten to dwarf all private and public efforts to craft incentives that promote efficiency and equity in the health care market. While moving to standardized benefits packages allows the consumer to make apples-to-apples comparisons of plans and discourages risk selection based on benefit design, it does not get to the heart of a health plan's capacity to risk select. Failure to adequately address risk selection will continue to have serious consequences both for access to care among vulnerable populations, and for the financial viability of health plans.¹⁹ In order for competition to work, health plans must compete only on efficiency (a comparison of output - a medical service - with the cost it took to produce) and quality and not on their ability to selectively enroll healthy patients or disenroll the sick.

The federal government and managed care advocates have proposed that the solution to risk selection is a system of payment adjustments to health plans known as *risk adjustment*.²⁰ There are two types of risk adjustment: *prospective* and *retrospective*. Under retrospective risk adjustment, all of the health plans in a market are required to pay a portion of their premium income into a pool which is used to reimburse the plans in a manner that is proportional to the number of high cost patients for which they are responsible. In prospective risk adjustment, at the beginning of each year - before their enrollees use any services - an individual's capitation payment to the HMO would be increased or decreased based on their characteristics (e.g., age, sex, residence, etc.) that contribute to their probability of being sick.

There are several approaches the State could take:

- as empirically sound prospective adjustments become available those adjustments could be incorporated into the capitation payments for State employees and Medicaid recipients;
- mandate coverage for high cost cases for all State residents;
- set up a fund that is dedicated to high cost patients so that retrospective adjustments could be made to health plans;
- monitor enrollment and disenrollment of high cost patients among the health plans and;
- monitor health plans to assure that patients receive the medically recommended protocol for the specific conditions involved.

2. Organize Purchasing Activities to Enhance Competition.

Recommendation 5. Establish a statewide health insurance purchasing alliance for small employers and for individuals.

A health insurance purchasing alliance is a private organization that secures health insurance coverage for the workers of member employers who have chosen to participate. The primary goal of such an alliance is to obtain better value (cost and quality) in purchasing health insurance by consolidating responsibilities and resources. A purchasing alliance can also foster competition (by reducing risk selection and assisting employees to choose a health plan) and reduce the overall level of the uninsured (by making insurance more affordable).

Functions that a purchasing alliance performs are:

- negotiating and contracting;
- marketing and enrollment;
- premium collection and distribution;
- data analysis and evaluation; and
- plan performance measurement.

A health insurance purchasing alliance builds on market reforms and operates best with the kind of insurance reforms that are working in New Hampshire.

The planning work revealed a great deal of interest in the concept of a statewide purchasing alliance for the small group market and perhaps (separately) for the individual market. It is believed that this could address some of the problems small employers and individuals face in purchasing coverage. The consolidation of health plans and provider groups gives small buyers even less power than they had before. Since 94% of the employers in New Hampshire have fewer than 100 employees and 70% of New Hampshire's employees are in firms with fewer than 100 employees, the small employer's ability to select a health plan at the best possible price might need to be augmented. The experience in California, Florida and other states that have state sponsored purchasing cooperatives for small businesses is encouraging.²¹ Through group purchasing, small businesses and individuals have access to a wider range of choices at less cost. The experience from other States indicates the need to keep the cooperative open to bids from all health plans and to encourage independent insurance agents or brokers to sell the cooperative's products.

Some purchasers will prefer to form a coalition for reasons other than purchasing health insurance as one group. The New Hampshire Health Care Purchasers Roundtable is an example of such a coalition. Larger purchasers of health coverage in New Hampshire,

both public and private (including the Department of Health and Human Services), have come together to form the Roundtable.

(See also APPENDIX B for further discussion of the Health Care Purchasers Roundtable).

3. Subsidize Private Market Coverage and Support Safety Net Providers and Delivery Structures.

There are two significant factors that contribute to the lack of health insurance coverage. The first is a lack of access to insurance through an employer. Slightly over half (51.2%) of all uninsured persons in the United States work full time, and 59% of all uninsured children live in families with a full time wage earner. The second is a lack of affordable coverage. Even though a majority of the uninsured work full time, the lack of affordable health insurance options plays a large part in the inability of the uninsured to obtain health care coverage. Health insurance premiums in the individual market are simply unaffordable for many low wage workers. While more employers offered health insurance during the late 1980s through mid-1990s, more employees declined coverage due to the shift of the cost of increased premiums and out-of-pocket costs to working families.²² Research indicates that families do not have enough disposable income to purchase health insurance until family income reaches 250% of the federal poverty level, or \$41,125 for a family of four.²³

New Hampshire exceeded the national average of employers who offered health insurance - ranking 9th among the 50 states and the District of Columbia (all 6 New England states ranked in the top 15).^{24 25} Nationally, the firms most likely to offer health insurance coverage are the larger, older, unionized businesses, with fewer low-wage and part-time workers. Businesses in retail, construction and agriculture/forestry/fishing are the least likely to offer health insurance to their employees. Table 3 shows how NH businesses compared to the United States.

Table 3**Private Establishments, Percent Offering Health Insurance, and Percent with Other Characteristics²⁶**

	US	NH	NE Avg %	NE Range
Number of Establishments	6,276,800	33,300	58,000	20,400 - 149,800
Percent offering health insurance	51.6	57.5	59.1	55% - 64.5%
Rank	---	9	---	3 - 14
Percent with 50% or more employees that are low-wage	16	12	11.9	9.9 - 14
Percent unincorporated	33.2	37.7	31	20.9 - 37.7
Percent in business less than 5 years	12.4	13.6	12.2	10.4 - 14.8
Percent in retail	23.2	30.4	24.2	19 - 30.4
Percent with 75% or more employees that are full-time	60.3	56.1	54.7	52.6 - 57.9
Percent in manufacturing	8.1	8.3	9.2	6.9 - 11.8
Percent in multi-State firm	13.8	13.3	11.8	10 - 13.3
Percent with union employees	3.2	0.9	2.2	0.9 - 4.2*
Percent in metropolitan area	78.7	69.1	76.3	29.9 - 100

* Includes two states (ME (1.5%) and VT (1.3%)) whose figures did not meet the standard for reliability or precision.

While the news was good regarding the percentage of businesses that were offering health insurance in New Hampshire (at the time of the study), it was tempered by the fact that NH also had higher percentages of businesses that are less likely to offer coverage - newer, non-unionized and retail firms. In addition, there are fewer firms in the State that have more than 75 percent full-time workers (NH firms are also primarily small businesses).

The discussion below on **Subsidizing Private Market Coverage** can be referred to as a "population-based" solution - the responsibility would be placed on the individual to choose health insurance coverage (another alternative would be to subsidize an individual's coverage through his or her employer - or an "employer-based" solution).

Subsidizing Private Market Coverage

The District Councils supported the incremental implementation of voluntary health insurance coverage. In order to expand the opportunities for New Hampshire's uninsured to purchase health insurance coverage, the State must determine:

- the scope of the health care benefit package and its probable cost;
- who will be eligible for the benefits package;
- the best estimate of numbers of uninsured children and adults in the state;
- the amount of revenue needed to support the expansion of insurance coverage; and
- the process of establishing and administering the expansion.

Principles of Expansion. District Councils discussions have yielded a consensus on a number of key aspects of financing coverage. In short, the debate about how to best further the goal of achieving universal coverage for health insurance revolved around the appropriate role of government in regulation of the health care market. A large majority of participants agreed that the following principles should be part of any expansion of coverage.

- Health care coverage, especially preventive care, for the uninsured is a State concern.
- All individuals should pay something towards the cost of their care, no matter how small an amount.
- Individuals should contribute to the control of costs, i.e., engage in preventive behaviors such as not smoking and exercising on a regular basis.
- The State is responsible for establishing the benefit package that will be available to the uninsured.
- The cost of coverage should be subsidized for individuals who could otherwise not afford it.
- The expansion of coverage should not encourage employers to drop private coverage for some employees in favor of public coverage (the "crowd out" phenomenon).

Recommendation 6. Provide a subsidy for the purchase of private insurance coverage for those who are uninsured because they cannot afford it.

The expansion of coverage to the uninsured would be accomplished incrementally. Step I of would expand opportunities to purchase health insurance coverage for a large portion of the uninsured children in New Hampshire. Children living in families that earn between 185% and 300% of the poverty level would benefit from this program. Coverage would be available on a subsidized basis dependent upon the family's income level.

Step II would expand opportunities for uninsured adults to purchase health care coverage. Families earning between 100% and 300% of the federal poverty level would qualify for this program. As with the children's expansion, adult coverage would be available on a subsidized basis dependent upon family income.

All options for expansion of coverage to the uninsured require cost sharing between the federal government, the State, and individuals. Individuals would contribute to the cost of expansion through premium payments, some portion of which would be subsidized dependent upon family income. The federal funds would flow from three sources: the current Medicaid Program, the Children's Health Insurance Program (CHIP) established under the 1997 Balanced Budget Agreement, and dollars available through a Medicaid Managed Care Waiver proposal.

Step I. Expansion of health insurance coverage to uninsured children.

Medicaid Outreach. It is estimated that 40-50% of NH children eligible for Medicaid are not enrolled in the program in New Hampshire. Of the estimated 18,000 uninsured children, approximately 8,000 of these children are presently eligible for Medicaid. The 1997 Balanced Budget Act which established the CHIP requires states to enroll all eligible children into Medicaid and provides federal funds for outreach.

In New Hampshire, children in families below 185% of the federal poverty level qualify for Medicaid. Enrolling as many eligible children as possible into the Medicaid program would reduce the number of the uninsured. The federal government would finance one half the cost of enrolling the estimated 8,000 eligible children into the Medicaid program, with the state paying the other half as a result of this expansion falling under the extension of the current Medicaid program. Assuming the 8,000 children under 185% of the federal poverty level would be covered under the Medicaid program, that would leave approximately 12,000 children in New Hampshire between 185% and 400% of the federal poverty level who would remain uninsured.

Child Health Insurance Program (CHIP). The most likely vehicle for the initial expansion of coverage to children is the Children's Health Insurance Program (CHIP), authorized under Title XXI, the 1997 Federal Balanced Budget Act. Under this program, the federal government will contribute 65% of the cost of the expansion with the state contributing the remaining 35%. Under the CHIP eligibility formula, New Hampshire children in families between 185% and 300% of the federal poverty level would qualify for the program.

Medicaid Managed Care Waiver. Children living in families between 300% and 400% of the federal poverty level could gain coverage through a Medicaid Managed Care Waiver. The estimated cost of expanding coverage is highly variable, dependent upon such factors as the premium cost of the benefit package, assumed program participation rates, and the degree of cost sharing between the federal government and the State.

Step II. Expansion of insurance coverage to uninsured adults.

Step II of the initiative would expand opportunities for uninsured adults to purchase health insurance coverage up to 300% of the federal poverty level. It is estimated that there are approximately 100,000 uninsured adults in New Hampshire. The expansion of health insurance coverage to adults is substantially more expensive than expanding coverage to children - adults are more intensive users of the health care system - and their health care claims experience is reflected in higher premium rates. As with the expansion of coverage to children, the expansion of coverage to adults would be accomplished by a combination of federal, State, employer and individual premium dollars.

Obtaining the Resources to Expand Coverage to the Uninsured

As briefly discussed above, expanding coverage to the uninsured depends upon a partnership between the federal government, State government, and New Hampshire's citizens. Obtaining the dollars necessary to expand coverage would require the re-direction of current health care expenditures, the raising of new revenues, or both.

A number of other states have implemented initiatives to cover both uninsured children and adults. In order to finance expansions of coverage, states have pursued a variety of strategies, most of which fall into these broad categories:

- Limited pools of money that are non-renewable;
- Re-allocation of current spending;
- Dedicated revenues; and
- Employer dollars leveraged through purchasing alliances.

Limited pools of money that are non-renewable, such as:

- Medicaid Enhancement Funds that NH Hospitals utilize for services to Medicaid enrollees and other low income patients;
- dollars from the federal Tobacco Settlement currently under negotiation between the White House and the Congress; and
- Community Benefit Agreements that arise from the sale or merger of non-profit assets to another non-profit or for-profit entity (these agreements are negotiated by the parties to ensure that non-profit assets being used to provide health care services and benefits remain in the available community for that use).

Re-allocation of current spending through:

- individual accountability to improve health status and reduce costs through lifestyle choices;
- application of research that indicates a wide variation in costs for the same medical procedure in different geographic areas (establishment of medical protocols holds some promise for redirecting resources - outcomes research and best practices models are examples of this approach);
- rigorous analysis of current health care spending within New Hampshire to determine where health care dollars are currently being spent and where reallocation is possible; and
- redesign of categorical grant programs in order to decrease duplicative administrative functions (which may require application for federal waivers).

Dedicated revenues, such as:

- cigarette tax increases dedicated to the subsidization of expansion costs (\$1.8 million is raised for every penny increase in the cigarette tax - Vermont and Massachusetts financed their health care expansions this way; CHIP is financed through the federal tax on tobacco) and;
- provider taxes or health plan assessments (revenue raised from these sources would comprise a pool of dollars that could support coverage expansion).

A Note on District Council Reaction to Financing Options

During the month of January, 1998, the Office of Planning and Research staff held meetings with the District Councils to identify their preferences for financing options to support the expansion of health insurance coverage to both uninsured children and adults. The information presented above (in Subsidizing Private Market Coverage) was discussed with District Council members.

There was significant agreement among District Council members on the strategy to cover uninsured children first, which was seen as a meaningful foothold to initiate a program that could be expanded to adults. Most felt that the State would need to obtain the funds from several sources concurrently (e.g., non-renewable revenue sources like the Tobacco Settlement combined with dedicated revenues such as the cigarette tax). There was also support for an assessment on health care carriers and the concept of purchasing cooperatives. Some saw the purchasing cooperatives as a means of forcing efficiencies in the health care market that might allow for re-direction of dollars.

Participants urged the State to use caution in redesigning any categorical grant programs - block grants to communities could result in certain groups being excluded from services. The adoption of any "block granting" process should be a financing mechanism that permits community organizations to pursue a set of goals and objectives held in common with the State.

Participants supported the concept of developing ways to capture savings from the current health care system and re-direct them elsewhere, however, identifying the mechanisms to accomplish this goal proved elusive. While members still thought savings could be realized when individuals adopted healthier lifestyles, they recognized that this was a long term proposition.

What follows in the section on **Safety Net Providers and Delivery Structures** can be described as a "provider-based" solution. Community health centers, hospitals, clinics and other providers that disproportionately care for the uninsured and the underinsured might require direct financial subsidies. If every resident within the State had health care coverage, direct subsidies would not be necessary. Until that happens, however, serious consideration must continue to be given to supporting these providers. The provision of health-related non-medical services as well as the adequacy of the delivery system and structures also improve access to care.

Safety Net Providers and Delivery Structures

The recommendations in this section take into account the fact that voluntary and incremental expansions of health insurance coverage will always leave a certain number of uninsured. They also take into account the fact that universal coverage, even if it is realized, may not guarantee that everyone will have access to all needed health care services. This is especially true for persons with special needs such as the need for transportation assistance or other health-related non-medical services.

Recommendation 7. Determine the scope of "safety net" services that should be available, the necessary level and sources of funding to maintain these services, and who should provide the services.

The "safety net" consists of those institutions, programs and providers devoting substantial resources to serving the uninsured and vulnerable populations. Although any provider can participate in the safety net, community health centers, hospitals, clinics and categorical providers (family planning, child health and prenatal services) are generally considered to form the core safety net institutions.²⁷ Perhaps the most persistent problem facing the State is what will become of the publicly-funded "safety net" programs. Privately-funded efforts that extend services to the uninsured, such as the Seacoast HealthNet, HealthLink (in the Lakes Region), and the Greater Derry Community Health Services face similar concerns.

The number of uninsured individuals in New Hampshire could be decreased by some of the present initiatives the State is undertaking which are discussed above. However, a

substantial number of people will remain uninsured during the transition stages of incremental reforms (moving towards universal coverage) or due to voluntary participation.

Both Minnesota and Oregon offer insights to New Hampshire as to what can be achieved through incremental and voluntary reforms. In the case of Minnesota, recent analysis has shown that MinnesotaCare has been successful in keeping the number of uninsured low and stable at six percent²⁸ (while the number of uninsured children dropped by 40%, the number of uninsured single adults had increased from 29% to 36%). As for Oregon, the Oregon Health Plan has made significant strides in decreasing the number of uninsured, but officials estimate that they expect five to eight percent of Oregonians will remain uninsured.²⁹ This factor and Oregon's experience to date, has generated a great deal of concern around the status of Oregon's safety net providers (particularly community and migrant health centers). As a result, the state decided to conduct a study as to whether these providers are suffering adverse risk selection and to award a series of grants to collaborative community partnerships of safety net providers (hospitals, businesses and consumers) "to preserve needed safety net capacity."

Participants in the health care planning work have supported the view that the State should continue to provide the needed care for uninsured and vulnerable populations by maintaining a provider safety net of health and social services. There was strong local support for assuring that "safety net" services and "essential local providers" were protected. However, there was no consensus as to the necessary extent of the "safety net" system, where resources should come from, the extent to which these services should be provided through health care coverage, or how these services should be integrated at the community level.

Participants in the planning process voiced a concern that the total resources committed to charitable care and other forms of non-reimbursed care were disappearing. The pressure in the evolving health care system is not only to squeeze out the inefficiencies but to eliminate cross subsidies.³⁰ If cross subsidies among patients are eliminated, over time, providers without endowments and independent sources of income will be unable to provide care to the uninsured.

Safety net providers tend to rely on Medicaid for a large portion of their revenues. The movement of the Medicaid population into managed care and changes in federal law could result in decreased revenues and a decreased capacity to care for the uninsured and vulnerable populations. While reports from around the country indicate that access to primary care services for Medicaid Managed Care enrollees have increased,³¹ the ongoing changes in Medicaid and the market (e.g., increased competition among providers, decreased capitation rates, and the transfer of more risk to contracted providers) suggest greater challenges in the future to safety net provider's ability to sustain their current levels of services to the uninsured.³²

The changing health care environment will require ongoing monitoring of resources and the needs of the uninsured and vulnerable populations. The changes in Medicaid and the

market need to be tracked at the State and national levels. Safety net providers should be monitored for "early warning signals" (patient volume, services and financial status) and the uninsured surveyed to find out if they have trouble getting appointments for care.³³

Recommendation 8. Support and promote systems that coordinate health-related non-medical services with medical care to improve outcomes.

Participants in the planning process spoke of what they wanted for themselves and their family members. Many focused on the importance of health-related non-medical services (such things as counseling, nutritional services, social work, personal attendants, homemaker care, transportation, etc.). Some argued that they were more important than medical care. Individuals pass through different stages as they try to achieve their highest level of function and independence. Each stage requires a different mix of medical and health-related non-medical services.

The Health Care Transition Fund Community Grant Program projects provide examples of how communities are working on the structural changes in the delivery systems that coordinate both medical and health-related non-medical services. A prime example of this is the development of integrated service networks that are being designed to meet community needs. Proposed pilot projects in the draft long term care plan for Medicaid recipients *Shaping Tomorrow's Choices*³⁴ also illustrate the recognition that both types of services are important to an individual's health status. Where possible, the Department will also pursue opportunities to combine categorical funding in support of integrated service delivery.

Ensuring a Minimally Adequate Delivery System

Certificate of Need

Recommendation 9. Revise the role of Certificate of Need to keep pace with the rapidly changing health care market.

"A Certificate of Need (CON) is issued by a governmental body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment, or offer a new or different health service. Such issuance recognizes that a facility or service, when available, will meet the needs of those for whom it is intended. CON is intended to control expansion of facilities and services by preventing excessive or duplicative development."³⁵

The State controls the supply of hospitals, nursing homes and other institutional settings through the Certificate of Need process. Before providers can construct new facilities, before renovations in excess of \$1.5 million in acute care hospital or \$1 million in nursing homes or specialty hospitals can begin or before equipment that costs in excess of \$400,000 can be purchased, providers must receive approval from the State.

CON traces its formal origins to federal legislation - the 1974 National Health Planning and Resource Development Act. Academics and government policy analysts assumed that supply drove utilization and costs - that a built hospital bed was a filled bed. Certificate of Need was born in a time when fee-for-service and cost-based reimbursement were the dominant forms of reimbursement and providers were unaligned and independent agents. Hospitals and nursing homes were able to shift the risk of their investments in construction and equipment onto consumers because they were paid on the basis of cost (an incurred cost was a reimbursed cost). Rather than change the reimbursement systems, government chose to impose controls over the supply. In practice, the process was generally ineffective.³⁶

When Congress failed to reauthorize the CON legislation in 1987, many states continued to fund the CON agency on their own. Although 35 states currently have CON programs, they are coming under closer scrutiny.

The evolving health system, on the other hand, encourages price competition, increasingly relies on capitation and fixed prices to pay providers and tends to discourage the unnecessary use of services. If private investors build unnecessary facilities or buy technology that is underutilized, the investors will lose money. In this environment, the importance of Certificate of Need is diminished. The State should consider alternatives or modifications to a regulatory mechanism that is premised on reimbursement mechanisms and provider structures that are in the process of being phased out.

In the new health care system one compelling reason for maintaining CON would be to protect medical shortage areas. As noted below in the discussion of the minimum delivery system, some areas within the State have an inadequate supply of providers and may require government support. Certificate of Need could be used to insure the integrity of these fragile delivery systems. Instead of acting as a barrier to entry - CON would be used as a barrier to exit for these areas. A Certificate of Minimum Need could be created that would give preferential treatment to institutions, equipment, or providers in medical shortage areas.³⁷

Another reason for maintaining a CON function in the new health care market is the issue of "niche markets". The market allows entrepreneurs to provide services in profitable niche markets: outpatient surgery, cardiac care centers, cancer centers and rehabilitation facilities. By siphoning off the business for the profitable services, these niche providers reduce the capacity of community hospitals to subsidize the uninsured or provide needed but non-profitable community services. Some have argued that niche providers are successful because that are more effective and less expensive than their competition; that the health care system needs more of them, not less.³⁸ If niche providers fail to provide community benefits, they could be taxed or required to provide community benefits. Those revenues could then be used to pay for the care of the uninsured and other community benefits.

Appropriate Standards for a Minimum Delivery System

Recommendation 10. Work with communities, market and provider representatives to establish both minimum standards of adequacy for the delivery system and a process and incentives for encouraging providers to practice within medical shortage areas or areas that do not meet minimum standards of adequacy.

These standards should be based upon the dominant organization of care and the nature of the community and its needs. A guarantee of coverage for services is meaningless unless the delivery system has the capacity to provide those services. The movement towards universal coverage not only implies a benefit package; it also implies a minimum delivery system.

When systems are in transition, definitions for adequacy begin to vary. In 1980, the Graduate Medical Education National Advisory Committee projected that the United States would need 79 primary care physicians (Pediatrics, Family Practice, Obstetrics and Gynecology and General Internal Medicine) per 100,000 population in 1990. Studies of staffing patterns in large established high quality HMOs during the 1990s indicate that 56 primary care physicians per 100,000 residents is adequate. The federal government defines an area as medically underserved if it has fewer than 33 primary care physicians per 100,000 residents. In the future, one expert has predicted that HMOs may employ as few as 20 primary care physicians per 100,000 population. Which ratio should the State use to guarantee that every resident has adequate access to primary care: 79, 56, 33 or 20 per 100,000 residents?

The answer is that State may have to use all four. If a fee-for-service system dominates, a fee-for-service standard should be employed. If HMOs dominate, an HMO standard should be employed. If HMOs and fee-for-service are working side by side, a blended standard might work. If neither system has a presence - that is, if the delivery system is so minuscule that the designation fee-for-service or HMO is meaningless - then the State may have to respond with a standard for a minimum system, such as the federal standard for medically underserved areas. Finally, if a managed care system can demonstrate that it can meet the primary care needs of its enrollees with fewer than 33 primary care physicians, then that standard should be given provisional approval. The provision is that the residents in the area must find the care acceptable and that the health status of the population must not decline. New Hampshire has approximately 750 primary care physicians for the full population, estimated at 1,138,000 in 1996, for a provider to population ratio of 65/100,000.

The distribution of primary care providers, however, is uneven, with many rural and northern communities coping with shortages and with the majority of primary care physicians working in the larger population centers in the southern part of the State. In addition, adequate numbers and access for the general population may not mean access for vulnerable populations, particularly the disabled or poor for whom a relatively short distance may present a major barrier to care. In a rural community, two miles to care for

an elderly person who is unable to drive, or two bus rides in a city for a single mother with children may present significant barriers to care.

Monitoring of the numbers of providers within individual communities or regions, rather than a statewide average is important and adds two critical dimensions to the discussion:

- How should the service area be defined for each of the covered benefits? Should they be defined individually (e.g., one for primary care physicians, one for hospital services, etc.), as a package of services (e.g., the service area for a licensed HMO), or in terms of the residential distribution of citizens?
- When should the providers be brought to the community, and when should the community be brought to the providers?

The Department of Health and Human Services currently assists areas with primary care provider shortages (as defined by federal standards) through loan repayment and other incentive programs, to attract and keep primary care physicians, nurse practitioners and physician assistants. The Department also assists communities to recruit for these providers through its support of the Recruitment and Retention Center within the Bi-State Primary Care Association.

These same approaches of shortage designation (based on State criteria) - incentives and recruitment services - could be used for all providers (e.g., dentists, physicians, nurse practitioners, physician providers, etc.) needed to meet a standard of adequacy for the State's delivery system.

¹⁴ Monopoly refers to the market condition that exists when there is only one seller with exclusive control of a service that makes it possible to manipulate prices.

¹⁵ Oligopoly refers to the market condition in which prices and other factors are controlled by a few sellers.

¹⁶ As a short term measure to address the crisis in access to insurance coverage in the individual market, the New Hampshire Insurance Department is implementing a risk adjustment and risk subsidy mechanism for that market only. All health insurance carriers in all markets will be assessed an amount that is based on their number of covered lives. The fund generated in this manner will be used to offset expenses for high cost patients among carriers that currently offer insurance policies in the individual market.

¹⁷ State of New Hampshire, Insurance Department, *An Analysis of the Non-group Market with Recommendations for Change*. October 27, 1997.

¹⁸ Randall Elliss and Thomas McGuire, "Setting Capitation Payments in Markets for Health Services," *Health Care Financing Review*, Vol. 8, No. 4. Summer 1987, p. 61.

¹⁹ Annie Gauthier, Jo Ann Lamphere and Nancy Barrand, "Risk Selection in the Health Care Market: A Workshop Overview," *Inquiry*, Vol. 32, No. 2., Spring 1995, p. 15. Nancy Barrand is a senior program officer in the Robert Wood Johnson Foundation.

²⁰ The Health Care Financing Administration is in the process of collecting data on Medicare managed care enrollees with the expressed purpose of developing prospective payment rates to health plans. The Balanced Budget Act of 1997 requires that the payment system be in place in the year 2000.

²¹ Presentations by Sandra Shewry, Deputy Director of California's Benefits and Plan Relations, and Rick Lutz, Director of the Florida Division of State Health Purchasing, "Purchasing Cooperatives: Expanding Access Through Market Based Initiatives." Coming of Age in State Health Reform, National Academy for State Health Policy, Portland, Maine, August 11, 1997.

²² The Lewin Group, *Paying More and Losing Ground: How Employer Cost-Shifting is Eroding Health Coverage for Working Families*, AFL-CIO, Washington, DC, February 19, 1998. See also P. Cooper and B. Schone, "More Offers, Fewer Takers for Employment-Based Health Insurance: 1987-1996", *Health Affairs*, (16)6, pp. 142-149, 1997.

²³ D. Chollet, "Who are the Uninsured" at the AHCPR *What Do We Do About the Uninsured?: Options for States*, Charlottesville, VA, September 15-17, 1997.

²⁴ Centers for Disease Control/National Center for Health Statistics, "Employer-Sponsored Health Insurance: State and National Statistics," Hyattsville, MD., 1997.

²⁵ This study was done in 1993. At this point in time, there is no more current information on NH employers. This is a potential topic for a statewide survey.

²⁶ Ibid. Adapted from Table 5, p.23.

²⁷ Raymond Baxter and Robert Mechanic, "The Status of Local Health Care Safety Nets", *Health Affairs*, vol. 16, no. 4, July-August 1997, p. 9.

²⁸ K. McCall, "Who Is Still Uninsured in Minnesota?", *JAMA*, (248)14, pp. 1191-1195, October 8, 1997. This analysis also found that the main barrier to insurance was cost and that the program had not caused employers to drop coverage. MN received a Medicaid Section 1115 waiver in 1992 for this program.

²⁹ Correspondence from Bob DiPrete, Director, Oregon Health Council, to C. Shannon, NH DHHS, Office of Planning & Research, February 13, 1998. Oregon received one of the earliest Medicaid Section 1115 Waivers.

³⁰ "Cross subsidies" are those instances in which one patient, e.g., a privately insured patient, is charged more than their costs in order to pay for another patient that was uninsured.

³¹ Suzanne Felt-Lisk, Mary Harrington, and Anna Aizer, "Medicaid Managed Care: Does it Increase Primary Care Services in Underserved Areas?", Mathematica Policy Research, Inc., for the Health Resources and Services Administration, Bureau of Primary Health Care, November, 1997.

³² One set of NH safety net providers - community health centers - reported a significant increase in the numbers of uninsured seeking their services during 1997. A study is being conducted to confirm those numbers and describe who these people are and why they are uninsured.

³³ Op Cit. "Medicaid Managed Care: Does It Increase Primary Care Services In Underserved Areas?"

³⁴ NH Department of Health & Human Services. *Shaping Tomorrow's Choices: A Report to the New Hampshire General Court on Long Term Care* DRAFT, Concord, NH, January 21, 1998.

³⁵ Alpha Center. *Glossary of Terms Commonly Used in Health Care*, Washington, DC, 1996.

³⁶ During the 1970s and early 1980s research on Certificate of Need programs offered a general indictment of Certificate of Need. For example, Salkever and Bice found that CON slowed the rate of change in the bed supply, increased assets per bed, did not change total hospital assets and had no effect on hospital costs. D. Salkever and T. Bice, "Certificate of Need and Hospital Costs," in M. Zubkoff, I. Raskin and R. Hanft (eds.), *Hospital Cost Containment: Selected Notes for Future Policy*, New York, PRODIST, 1978. See also, F. Sloan and B. Steinwald, *Insurance, Regulation and Hospital Costs*, Lexington, MA, Lexington Books, 1980; and, F. Hellinger, "The Effects of Certificate of Need Legislation on Hospital Investment," *Inquiry*, June, 1976.

³⁷ The definition for a medical shortage area would have to be developed. It could be a composite of the federal standards for Medically Underserved Areas or Health Professional Shortage Areas. On the other hand, the standards might need to be more stringent. The shortage area designation should not be co-opted by local providers to protect themselves from change but directed only at areas struggling to maintain a minimum delivery system.

³⁸ A. Myerson, "The Battle for Hearts and Tonsils: Hospitals Specialize to Enhance Profits," *New York Times*, October 7, 1997, pp. D1., D4.

II. Strategies for State Action:

B. Protecting and Empowering Consumers

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Participants in the health planning work frequently voiced concerns about having a neutral party to go to with complaints and needing assistance to navigate the appeals process of managed care. Real or perceived threats to the quality of care was another major issue, as was the lack of information to make informed decisions. Some providers saw the ability to form new managed care entities as crucial to maintaining competition and consumer choice.

The health care industry in New Hampshire is undergoing a historic transformation as more people enroll in HMOs and other types of managed care plans. The State saw a 25% increase, from 191,000 to nearly 240,000 members, in underwritten managed care enrollment between 1994 and 1995 and an increase of 18% , from nearly 240,000 to 282,000 members, between 1995 and 1996.³⁹ In 1996, the underwritten managed care market penetration reached 25%, up from 22% in 1995.⁴⁰ When self-funded business is included, New Hampshire's managed care market penetration rose to 39% in 1996.⁴¹ In the small group market that shift has been dramatic - during 1998 HMO enrollment for this population is expected to reach 80 percent.⁴² As the shift to managed care was underway, two health insurers in the State established control of 77% of the managed care market in 1996 (CIGNA/HealthSource (46% of the market), and Matthew Thornton (31% of the market). In 1997, Blue Cross/Blue Shield purchased Matthew Thornton. Had that taken place in 1996, their combined market share would have been 50%.⁴³) Recently released national data shows that four out of five employers who sponsor health insurance offer only one plan to their employees.⁴⁴

A quick, fair and "user friendly" approach to dispute resolution might decrease some of the tension in the market-driven health care environment. Tracking complaints can establish whether a problem exists and improve quality. Information - the right information - benefits all market participants from the regulator charged with ensuring that an organization is financially stable or that services promised in a contract are delivered to the provider looking for "best practice" methods.

The core strategies in this section are to:

1. establish a system for conflict resolution;
2. assure the quality of care;
3. develop a State information infrastructure; and
4. assure the solvency of risk-bearing entities.

1. Conflict Resolution

Mediation

The speedy, fair and impartial resolution of conflict was one of the major issues raised during citizen discussions. Everyone was concerned - consumers, providers and purchasers. Most states rely on the internal grievance procedures of HMOs to resolve the problems that arise.⁴⁵ Since the State and the health plans were seen as having vested interests in the outcome of many conflicts, a number of individuals expressed the need for an impartial entity outside of existing State agencies and health plans that would be responsible for mediating the serious conflicts that occur between health plans, consumers and providers.

For the most part, the market has been the model for dealing with complaints. If someone did not like the way they were being treated by their health plan, they would register their disapproval by voting with their feet. They would leave the plan and sign up with another more responsive health plan. There are, of course, other ways to register disapproval. The most important one is voice, the ability to register complaints and grievances, to protest and to apply political pressure.

The consolidation of delivery systems and the restricted choice of health plans available makes leaving more difficult and voice more important than ever before.⁴⁶ Mediation is a means of removing tension from within the health care delivery system.

Recommendation 11. Establish an independent mediator, with the authority to make recommendations, for disputes arising among consumers, providers, health insurers and managed care organizations.

Mediation is the least intrusive - and usually least expensive - of a range of alternative dispute resolution techniques. Mediators have no power to force a solution or make a finding. They do not preclude legal action. Instead, they derive their power and effectiveness from the fact and the appearance that they are:

- unassailably neutral;
- skilled in the art of communication;
- competent; and
- trustworthy.

Mediation would not replace the appeals process available to individuals receiving services through the Department of Health and Human Services, the grievance procedures available through health plans and insurers, nor the legal options that may be available to consumers or providers. Mediation would be the final option, prior to legal action, to address issues and concerns that consumers and providers consider to be

unresolved through the normal grievance process. Records of referrals to and the outcomes of mediation would be available to all parties.

Recommendation 12. Create an independent consumer hotline for complaints regarding health insurance coverage.

The hotline would:

- provide basic information on consumer rights and obligations;
- identify information channels available to the consumer for resolution of complaints, including any appeals and/or grievance procedures available, and information on mediation;
- make referrals to State agencies, when warranted; and
- catalogue and regularly tabulate all complaints to identify patterns of problems and form recommendations for any corrective actions.

A consumer hotline permits careful and consistent monitoring of the tension within the health care delivery system.

2. Assuring Quality of Care

A consistent theme of the health planning work was a concern on the part of virtually all participants that New Hampshire residents receive quality health care services. In addition, there was a consensus that the State should be responsible for assuring that quality. Consumers and providers were concerned that health plans are increasingly under the control of out-of-state interests and that these interests may be unresponsive to New Hampshire community standards of care and access. The pressures to consolidate operations or merge local/regional delivery systems in order to keep their costs competitive could have a similar result.⁴⁷

Current New Hampshire governmental quality monitoring functions are limited to organizations registered as Health Maintenance Organizations, Medicaid, and categorical service contractors. There is an absence of State monitoring of self-insured plans which cover an estimated 280,000 residents (while the federal government - through the Employment Retirement Income Security Act (ERISA) - has created significant barriers, these are not insurmountable - see the discussion on pages 57-58).

As insurance plans in New Hampshire have abandoned the trend to vertical integration (i.e., acquisition of clinical practices to create a dispersed staff-model health maintenance organization), most providers have contracted with most plans. This makes allocation of a plan's responsibility for a community's health virtually impossible to measure, regardless of the development of more sophisticated outcome measures than currently exist. While

the focus of discussion about quality in the health planning work has been on managed care organizations, it is appropriate to focus quality monitoring efforts as much on provider/delivery systems as on health plans.

See also the discussion in Development of an Information Infrastructure for an individual or consumer approach to quality of care.

The Elements of Quality

For the purpose of this discussion, the Institute of Medicine definition of quality which is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge, is used. Monitoring the quality of care is complex and presents challenges that need to be acknowledged.

The three elements of quality which can be measured include inputs, process and outcomes:

- **Input measures** are those that examine the basic infrastructure of the health care delivery system. They are generally available, measurable, and reliable. Examples include the extent of service availability, the level of training which providers have achieved, the financial viability of health plans, and the operational capacity health plans can demonstrate (e.g., scheduling and billing). The fact that the infrastructure exists or meets some accepted standard does not guarantee quality care.
- **Process measures** are those which examine how a system functions, i.e., whether a system of care provides the services which it should, and whether it provides them efficiently or adequately. Examples include monitoring a health plan for the percentage of children in the plan who received appropriate immunizations and the number of eligible women who have received pap smears or breast cancer screening at the appropriate ages and intervals. They do not examine the patient outcome which may be associated with that service.
- **Outcome measures** are the most complete measures of health care quality and are the most difficult to quantify. In the past, outcome measurement has been largely limited to examination of easily counted events, usually in relation to a particular procedure. Researchers have begun to examine outcomes which are not so easily quantified, taking into account more subjective measures such as differences in overall health status. An increasing awareness of the importance of the role of overall quality of life and client/patient preference as principal measures has improved outcome measurement (quality of life has been discussed in the section on New Hampshire's vision and values pages 5-11). Examples include a patient's description of how she feels (sick or in pain) and whether or not she can perform her normal activities (such as working, shopping and cooking). A successful procedure or delivery of a unit of service is no longer a success if the recipient does not demonstrate an improved quality of life.

Recommendation 13. Promote and participate in an organization which would develop innovative quality monitoring and improvement activities.

Many District Council members believe the organization should be independent of State government and each of the stakeholders in health care across the State, although all should be invited to participate. The organization should not be an extension of the State's regulatory role, although it may serve as an informational and research resource for State government as well as for other health care organizations.

Organizations throughout the State have developed extensive and valuable quality monitoring activities of their own that could provide direction for such a venture. The New Hampshire Foundation for Healthy Communities, founded by the New Hampshire Hospital Association and supported by a broadly representative group of health care providers and health plans, has undertaken a series of quality evaluations for specific clinical problems. The Center for Evaluative Clinical Sciences at the Dartmouth Medical School has long been a national leader in studies of variation of procedure rates across communities.

New Hampshire's businesses, which are the major purchasers of health care services, represent additional important organizations who have their own interest in assuring the quality of health care services. They must balance their concern for the quality of the services which they purchase with their willingness to bear the expense of expanded monitoring. The creation of the New Hampshire Healthcare Purchasers Roundtable is evidence of the active interest of businesses in accessible, affordable and high quality health care for their employees.

The goal of quality assurance is to improve the quality of care, and hence the quality of life, of New Hampshire residents. This cannot happen without the engagement, participation, and cooperation of State agencies, businesses, insurers and health plans, consumers and their families and advocates, and the service providers in New Hampshire.

Recommendation 14. Develop a coordinated monitoring policy for all health care services for which there is current State legislative or regulatory authority.

As in many other states, quality measures are required by and reported to a variety of State agencies in New Hampshire. States are now considering new approaches to configuring State roles and authority, both because of duplication and regulatory gaps in oversight that need to be addressed. In some cases, several State agencies could be monitoring the same providers. This may become more significant in the future if the Department of Insurance extends licensure to Provider Service Organizations (PSOs) and the Medicaid population is moved into managed care.

The policy should include:

- a clear delineation of activities to be monitored by various State agencies, with the intent of eliminating redundancy and barriers to efficient reporting;
- nationally recognized consensus criteria for measurement (e.g., HEDIS [Health Plan Employer Data and Information Sets], QISMC [the Quality Improvement System for Managed Care] under development by the Health Care Financing Administration for both Medicaid and Medicare, and the Market Conduct Examiners Handbook currently being developed by the National Association of Insurance Commissioners) should be the predominant means of measurement;
- the capacity to manage and analyze the required data;
- an effective public education system which can reasonably report the findings of monitoring programs; and
- data and information reports which track progress and change over time.

Challenges in Measuring Quality

In summary, despite the demand and need for information on quality, there are challenges to establishing quality monitoring systems.

- There are no measures for all the things which we would like to know.
- It is not currently possible to link process indicators (such as HEDIS) for a health plan with population health outcomes for a community.
- Each health status indicator is affected by a wide spectrum of variables which are not influenced by medical care.
- Monitoring of the quality of health and social services is complex.
- Different technical and professional skills are required for each of the three elements (inputs, processes and outcomes) of quality in order to collect reliable information.
- Health care plans and systems must be responsive to the information which is reported to them.
- Health plans and provider systems may be resistant to State mandated surveillance data systems which are expensive or seen as redundant with their own systems.

See also the discussions on data and information in the sections on Development of an Information Infrastructure and Public Health.

3. Development of a State Information Infrastructure

Most states, including New Hampshire, do not have information systems capable of monitoring or supporting health reform. Funding, data comparability, and cooperation of providers and insurers will be issues the State must address if it is to construct a viable health care information system.⁴⁸

During the planning work, the District Councils repeatedly stressed the public's need for information that would allow individuals and communities to make informed decisions. Information is pivotal to the ability of consumers to select an appropriate health plan, employers to negotiate a fair price for their health insurance coverage, or providers to determine how their care compares to other providers in their area. Many stressed that the ability of communities to determine what their local health problems are or how successful interventions have been depended upon the kinds of health information available. Most felt that the State should be responsible for developing the information infrastructure.

See also section on Public Health - Core Role 1 - on the need for data collection and analysis.

Recommendation 15. Develop the capacity to provide data that allows citizens to review the health status of communities and the statewide population; to understand the performance of State and market functions; and to understand the status of community concerns.

State functions include the design of the benefit system, the financing of those benefits, quality, the fiscal solvency of risk-bearing entities and conflict resolution. Cost and quality information is necessary for the proper functioning of markets. Both the State and the market need to recognize and assess the contributions of non-profits and volunteers.

During periods of stability, information needs are minimal. Significant change, however, alters this. In the current market driven health care system, information needs are increased (for markets to work information must be available). Adequate information can reduce some of the uncertainty and some of the conflict; it may also serve as a substitute for regulation.⁴⁹ It can also improve the likelihood that the State will have a health delivery system that most of its citizens want with few of the elements that its citizens do not want.

The new delivery system is driven by market innovations. Markets work well only when the market participants have ready access to reliable and useful information. If the market is to work, information has to be made available to purchasers, consumers and providers of health care that is accurate and that educates while it informs. People have to be able to understand what the information means, and how it can be used. Perhaps more importantly, the information should assist them in making informed decisions. An example of such an attempt is the development of "report cards" for consumers.

Unfortunately, early evidence suggests that consumers are not using them to choose health plans,⁵⁰ due primarily to the fact that they do not understand the information and its organization, and the presentation ignores the way people make decisions.⁵¹

Several aspects of the Information Infrastructure place it properly within the jurisdiction of the State. Such information must be publicly available and its collection and presentation must minimize the self-serving interests of any specific participant in the system. In addition, the sharing of information and data between providers, agencies and organizations must be done with due regard for the confidentiality of individual personal records and business proprietary information.

Recommendation 16. Promote the private development of information that helps improve the health status of New Hampshire citizens and the operation of the health care system.

While aspects of the Information Infrastructure are within the State's jurisdiction, there are certain parameters to this role. The State's role is not simply to collect and present information that meets the needs of government. It must also meet the needs for the proper functioning of markets and communities. The State's information system will not and cannot be all inclusive. There are and should be the opportunities for the creation of new data by market and community interests. Indeed, the State should encourage other participants to contribute to new ways of seeing the world and new information that can improve the effectiveness of private participants. The contributions of the Foundation for Healthy Communities and the Foundation for Informed Medical Decision Making are cases in point.

See also the discussions and recommendations on public/private partnerships for data and information collection, analysis and dissemination in the sections on Quality Assurance and Public Health.

4. Assuring the Solvency of Risk-Bearing Entities

The Department of Insurance (DOI) requires that all health plans that assume any financial risk set aside money for unexpected losses. This assures consumers and providers that insurers will honor their promises to pay for services. During the planning process, the fiscal solvency requirements were referred to indirectly. They were discussed as burdensome barriers that prevented the system from moving on to what was really important. These fiscal requirements were broached at District Council meetings and focus groups in terms of provider difficulties or fears. Providers found it difficult to create local networks that met these requirements and expressed concern that they would be unable to bid on the Medicaid managed care contract because they were not an HMO.

The changing nature of the delivery system presents three basic fiscal solvency issues:

- How should the State treat new health care organizations?

- How should the State control the efforts of licensed risk bearing entities to shift risk onto subcontractors (e.g., an HMO shifting risk onto hospitals and physicians)?
- How should the State assist individuals when self-insured employer-sponsored plans that are not subject to State regulation collapse?

As new organizations proliferate and old ones are repackaged, the consumer's exposure to financial risk is magnified. Can the new entities deliver on their promises of care? In a market that places a premium on selecting the healthiest patients in the population, will the organizations with the sickest patients be able to pay for all of their care? Or, will individuals who thought they were insured, find themselves ill, facing financial ruin and unable to purchase the care they need?

New Health Care Organizations

New health care organizations without any performance history are being formed on what seems like a daily basis. Insurers and providers are raiding the alphabet in an outpouring of acronyms to describe new arrangements. In addition to HMOs, providers and insurers are organizing themselves into Provider Sponsored Organizations (PSOs), Integrated Delivery Networks (ISNs) and many other entities that claim to be distinct health care organizations. Some - like the HMOs - are clearly identified in State law, while most are not.⁵²

New Hampshire's insurance laws provide for the licensing and regulation of entities offering health care insurance. These entities include commercial insurance companies, nonprofit health service corporations and health maintenance organizations. The Commissioner of the Department of Insurance also has authorization to license systems of health care delivery and financing on a limited basis or on an exception basis (through RSA 420-B:23).

New Hampshire's Department of Insurance requires all risk bearing entities in the health care field to have at least \$6 million in financial reserves. The financial reserve can be considered as consumer protection from health plans that priced their product too low or that underestimated their risk.

Such high reserve requirements not only safeguard consumers; they are also barriers of entry into the insurance field. As the reserves increase, the financial demands on firms that want to sell their product in New Hampshire also increase. Smaller businesses may thereby be excluded from the market.

A new organization that wishes to assume risk is itself a risky proposition that warrants regulation. While the justification for the regulation is clear, the question before the Department of Insurance is whether the specific levels and amount of the financial reserves are so high that they are stifling the creation of new, viable and relatively safe businesses.

Recommendation 17. Establish licensure for health care organizations that bear financial risk based on a formula that adjusts capital and reserve requirements to the number of covered lives served by an organization, its structure, and the percent of risk that the organization will assume.

The National Association of Insurance Commissioners (NAIC) has taken a position that risk is not constant - it varies. NAIC has been developing a formula that would adjust capital and premium set asides to the number of covered lives served by an organization, its structure and the percent of risk that the organization has assumed. This is the NAIC's first attempt to recommend capital and reserve requirements for all risk assuming entities: insurance companies, HMOs and all of the health care organizations entering the market.

NAIC began to test the formula in a select number of states during the summer of 1997. New Hampshire was one of those states. The New Hampshire Insurance Department has worked to simulate the impact that the NAIC risk based formula would have on several health care organizations in the State. The Department has also indicated a willingness to work with these new organizations to develop alternative licensing standards.

Even with the NAIC adjustments, organizations in rural or medically underserved areas might require assistance or a partial exemption from the financial reserve requirements. The health care systems in rural and medically underserved communities, or which serve the uninsured or underserved, tend to be fragile and can be easily disrupted by the strong external forces of national and regional health maintenance organizations. The legitimate and reasonable concerns that regional health systems have for efficiency, effectiveness and profitability may run counter to the needs that a community has for access, convenience and job security.

The promotion of rural networks and networks targeted at the uninsured or underserved, however, should not impose unnecessary risks on consumers. Protection of the consumer may mean that alternative methods for financial guarantees need to be developed. This could take two forms:

- private sector joint ventures in which the community network provides the service and the insurance company underwrites the risk; and
- private/public joint ventures in which the State through one of its agencies would re-insure a community enterprise (i.e., the State would assume the cost of services that exceed a given threshold of expenses).

Down-Stream Risk

Recommendation 18. Develop guidelines governing the transfer of financial risk from one entity to another.

Another new development in the market driven health care system that can affect consumers and the quality of their care is known as "down-stream risk." Down-stream risk occurs when a licensed risk bearing entity shifts risk onto an organization or provider that is not licensed to assume financial risk. This occurs when a health plan transfers financial risk to providers under contract to the plan. For example, an HMO pays a hospital on a capitated basis (that is, the hospital agrees to provide all services the HMO needs for a fixed fee per person). The hospital, in turn, can transfer some of its risk onto individual doctors (who agree to provide all physician services that the enrollees might need for a fixed price per person). Each transfer creates different kinds of risk with different levels of exposure for both patients and providers.

Some subcontractors can absorb an underwriting risk. They are large institutions with large budgets and large reserves. As you move down the operational chain, however, the providers become smaller and their capacity to take on and absorb underwriting losses diminishes.

The Department of Insurance has an responsibility to assure the quality of care of all risk assuming entities. Down-streaming can affect the ability of a provider to allocate sufficient resources to care for their patients. Therefore, to the extent that risk is moved, the DOI has a corresponding responsibility to assure quality of care.

Self-Insured Employer-Sponsored Plans

With the passage of the Employee Retirement and Income Security Act (ERISA) in 1974, Congress reconfirmed the states authority to regulate insurance plans and Multiple Employer Welfare Associations (MEWAs) while allowing a new class of exemptions - self-insured employer-sponsored health coverage. Nationally, more than 40 percent of all workers are in employer-sponsored self-insured plans.

Self-insurance means that the employer assumes the underwriting risk for their employees and is exempt from State regulation. One of the many troubling aspects of this provision is that no federal requirements replaced the traditional State concerns for quality assurance and fiscal solvency. Since 1989, a number of self-insured New Hampshire plans have failed. The Department of Insurance has handled the proceedings for self-insured plans that have failed - extending essential services to New Hampshire consumers and providers. These services have included helping all involved parties reach a settlement on outstanding claims and arranging for third party administrators to process claim payments.

Recommendation 19. Establish the capacity to track the numbers of self-insured plans, require such plans to disclose to their enrollees that they are self-insured, and provide support and guidance to individuals insured under such plans.

Implementation of this recommendation would provide the basis for:

- an annual determination of the number of self-insured plans and individuals covered by those plans. This would permit the determination of the number of employees covered under self-insured plans and the circumstances that prompt employers to become self-insured under the Employment Retirement Income Security Act of 1974;
- mandatory disclosure by self-insured plans to inform their employees that the Employment Retirement Income Security Act (ERISA) does not require the employer to meet the State's financial reserve requirements, State mandated benefits, State quality assurance standards for health plans and consumer protection provisions. Many individuals are unaware that the plans they belong to are operated outside of the jurisdiction of the State and that the State cannot assist them. At a minimum the workers of New Hampshire should know and understand that their self-insured plans are not regulated or protected by the State of New Hampshire;
- a hotline for employees in self-insured plans to record the problems encountered within these plans. Since the State, providers and individuals assume the costs of failed self-insured health plans, the State should track how well or badly those firms are doing and whether the State needs to make new provisions for whatever new problems are developing; and
- a waiver to the Employment Retirement Income Security Act (ERISA) that would permit the Department of Insurance to work with consumers to resolve complaints against self-insured plans.

It is important to note that the Department of Insurance treats any efforts by self-insured plans to shift risk onto providers (the down-streaming discussed above) as bringing that portion of the plan into the State's jurisdiction. When an employer transfers the risk of excess medical expense associated with its employee benefit plan to a licensed insurer, that benefit plan is then treated under ERISA as a fully insured plan. That plan is then subject to State insurance regulation (policy forms, mandated benefits, premium rates, unfair trade practices, solvency requirements; taxation and other matters).

³⁹ Foundation for Healthy Communities, *Managed Care Market Analysis, A Northern New England Report*, Concord, NH, 1997, page 7.

⁴⁰ Ibid.

⁴¹ Ibid. A national analysis of the managed care market showed that the State's ranking moved from 11th to 2nd highest HMO penetration in the country: *Managed Care Digest Series. HMO-PPO Digest 1996*. Kansas City, MO, Hoechst Marion Roussel, 1996, pp. 16 -17.

⁴² J. Lee et al, *An Investigation into the Effects of the New Hampshire Health Insurance Reform Law*, RSA 420-G, Center for Health Economics Research/IMR Health Economics, LLC, NH Department of Insurance, Concord, NH, December 17, 1997. The authors of this report refer to the "death spiral" of indemnity insurance in the small group market.

⁴³ Ibid, pp 20-21.

⁴⁴ Op Cit. Centers for Disease Control/National Center for Health Statistics.

⁴⁵ At least 5 states - New Jersey, Rhode Island, Connecticut, Texas and Florida - have legislation requiring external review of final denials by managed care organizations. California Governor Wilson's Managed Health Care Improvement Task Force recommended (January, 1998) that the state establish an independent, third party review process by the year 2000.

⁴⁶ In New Hampshire 2 entities - Blue Cross Blue Shield of NH/Matthew Thornton Health Plan and CIGNA/HealthSource - dominate the health insurance market. See also CHI, "New Hampshire Network Survey Report", DHHS, Office of Planning & Research, Concord, NH, September, 1997, for a discussion on the 29 and health and social service networks that have formed or are in the process of forming in NH.

⁴⁷ The controversy surrounding the Manchester community and Optima Health provides an example. The Attorney General's office ruled (March, 1998) that Optima officials violated state law on charities by making promises they did not keep and changing the mission of CMC and Elliot Hospital without consulting the community (and the State and probate court). See *Boston Globe*, March 11, 1998, p. B5.

⁴⁸ The most appropriate means to collecting data elements - collaboration or regulation and through State staff, external contractors or public/private partnerships - must be determined.

⁴⁹ The Agency for Health Care Policy Research (AHCPR), in their report "Better Quality Can Cost Less", suggests that objective, scientifically sound and widely disseminated information can have a dramatic effect on the marketplace - encouraging better, more cost effective care without burdensome government regulation.

⁵⁰ J. Hibbard and J. Jewett, "Will Quality Report Cards Help Consumers?", *Health Affairs*, vol. 16, no. 3, pp. 218-228. See also J. Hibbard, P. Slovic and J. Jewett, "Informing Consumer Decisions in Health Care: Implications from Decision-making Research", *Milbank Quarterly*, vol. 75, no. 3, September, 1997.

⁵¹ In a 1997 report issued by Minnesota Consumers Organized Acting Together (COACT), "Strangled Competition II: The Quality of Health Care Under Managed Competition - The Promise and the Reality", report cards were determined to be "... financially infeasible, too broad in scope and lacking specific information on illness and providers." This group also criticized the 1995 Consumer Satisfaction Survey - produced by the Minnesota Health Data Institute - which ranked health plans as "... being useless to consumers...[it] did not contain cost data, benefit information or information on quality of care for a single illness or condition."

⁵² The 1997 Balanced Budget Act allowed for the creation of Medicare PSOs which could begin operation as early as 1999.

II. Strategies for State Action:

C. Re-Defining Public Health In the Evolving System

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Public health agencies are a lot like fire departments. They teach and practice prevention at the same time that they maintain readiness to take on emergencies. They are most appreciated when they respond to emergencies. They are most successful - and least noticed - when their prevention measures work the best. In another respect, the two are different. Everyone knows what a fire department does; few know what a public health department does. The very existence of health departments is testament to the fact that, when legislators, county commissioners, and other policymakers understand what those departments do, they support them. It is a rare person who, once familiar with the day-to-day activities of a public health department, would want to live in a community without a good one.

Source: Washington State Department of Health, 1994.

Public health services are population-based - that is, they "treat" the whole population instead of the individual, as is the case of personal health services. An example of public health (population-based services) would be a campaign on the importance of physical activity for all the residents in New Hampshire or Manchester or all the students at the University of New Hampshire. This differs from individual or personal health services, such as a visit to a provider for a physical exam or instruction on how to follow a diabetic diet. Most people probably do not even think of "public health" when they eat at a local restaurant, read a newspaper article on teenage smoking or listen to a public service announcement on wearing seat belts. Yet restaurant inspection, the collection and analysis of epidemiological data and public education on injury prevention are all examples of public health functions (a more complete discussion of public health roles follows under The Ten Core Roles of Public Health).

During the health care planning work, participants indicated that State government should continue to be responsible for maintaining public health functions. As the delivery system is transformed, it may also be transforming public health. The following needs to be resolved:

- the re-definition of public health;
- the determination of the impact that private and community reorganization of health care services have on public health;
- the decision on which public health functions should remain, be expanded, altered or eliminated in light of private and community reorganization of health care services; and

- whether the private sector should be held to a different standard than the public sector.

The federal Centers for Disease Control and Prevention and a variety of public health organizations have developed ten core roles for public health agencies in Table 4. Fulfilling these roles presents a number of challenges in the changing delivery system.

Table 4

The Ten Core Roles For Public Health	
1. Monitor health status to identify and solve community health problems.	
2. Diagnose and investigate health problems and health hazards in the community.	
3. Inform, educate, and empower people about health issues.	
4. Mobilize community partnerships and action to identify and solve health problems.	
5. Develop policies and plans that support individual and community health efforts.	
6. Enforce laws and regulations that protect health and ensure safety.	
7. Link people to needed personal health services and assure the provision of healthcare when otherwise unavailable.	
8. Assure a competent public health and personal health care workforce	
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.	
10. Research for new insights and innovative solutions to health problems.	
Turncock and Handler, 1995.	

Some of the roles are historical responsibilities for public health agencies (e.g., diagnosis and investigation of community health problems and the identification of health hazards), while others have become public health responsibilities by default, in response to failures in the health care delivery system (e.g., linkage to personal health services and assurance of the provision of health care when otherwise not available). Others are clearly roles which have been and must continue to be shared by public and private entities (e.g., evaluation of the effectiveness, accessibility, and quality of personal and population-based health services).

The ability of state and local public health agencies to fulfill the ten core roles varies considerably. Examination of capacity has indicated that it is partly determined by the ways public health agencies work with and gather support from the private sector and communities.⁵³ Capacity also depends on the dollars available to agencies for the provision of public health core functions. While approximately 1.6 - 2.7 percent of national health expenditures go to fund public health programs (that is 16 to 27 billion dollars), more than two thirds of those dollars are spent on the financing or direct provision of clinical and social services.⁵⁴ "Estimated Expenditures for Core Public Health Functions - Selected States October 1992 - September 1993", MMWR, no. 44, vol. 421, 1995. See also R. Brown, A. Elixhauser, et al, National Expenditures for Health Promotion and Disease Prevention Activities in the United States, Battelle Medical Technology Assessment and Policy Research Center, Washington, DC, 1991. In the new health care system, the allocation to public health services may be inadequate or excessive depending upon how public health roles are altered.

Recommendation 20. Collaborate with the Turning Point Steering Committee to reassess the functions of public health.

New Hampshire was one of fourteen states to be awarded a grant through the Robert Wood Johnson and the Kellogg Foundation's "Turning Point" initiative. The purpose of this initiative is to assist states in determining what the roles of public health will be in the 21st century and who will be responsible for carrying out those roles. Members of the Turning Point Initiative include the Department of Health and Human Services (DHHS), the Department of Education, the Department of Environmental Services, the NH Public Health Association, legislative representatives, the NH Municipal Association, the NH Medical Society, the NH Health Care Purchaser's Roundtable, Blue Cross and Blue Shield of New Hampshire, and representatives from three communities (Nashua, Manchester and Franklin). Much remains to be decided in the next several years, particularly what infrastructure needs to be in place at the State and local levels. This is an opportunity for State/local and public/private dialogue and decision-making around activities aimed at implementing the core public health roles in the future health care system.

The Ten Core Roles for Public Health

Recommendations for New Hampshire are presented at the beginning of the discussion on each of the ten core public health roles. The recommendations focus on determining the extent of the problem, the current capacity of all providers to respond to that problem, and steps to remedy the situation. Decisions on the proposals and recommendations should be based on a broad consensus model like that used in the Health Care Planning Process: with the involvement of stakeholder organizations, professional experts, and the State. As suggested above, the Turning Point initiative provides that vehicle.

1. Monitoring health status to identify and solve community health problems.

See Recommendation 15 - Development of a State Information Infrastructure.

Monitoring health status was discussed at some length during the development of the *Health Status Indicator Inventory*. The Department of Health and Human Services has consistently collected and reported a range of health data sets for specific areas of interest (e.g., the Cancer Registry and the Behavioral Risk Factor Survey). The DHHS has also developed the *Primary Care Access Data* which has been used statewide in conducting local needs assessments. A variety of other organizations are also involved in the collection and analysis of population-based data, such as the New Hampshire Hospital Association (the Uniform Hospital Discharge Data Set), the Department of Education (the Youth Risk Behavior Survey), the Children's Alliance (The Kids Count), and the Center for Evaluative and Clinical Sciences at the Dartmouth Medical School.

In consultation with external experts, a consensus should be developed on the extent and type of population health measurement efforts required, i.e., whether to maintain the current level of activity, provide expanded and more flexible analyses of currently available data sets, or add data sets which are identified as important to understanding the health status of New Hampshire's population. The decisions should be based on the resources, existing data sets, and methodologies available.

One possible solution - a Health Data Consortium - would address some of these issues. The Consortium could serve as a resource for information sharing; as a clearinghouse by a variety of organizations; and as a forum for discussion of data policy issues across a broad range of disciplines. It could also serve as a focus to attract funding for statewide data initiatives. The Consortium should not, however, be expected to preclude the need for the State to finance data and research activities which by consensus are assumed to be State public health responsibilities.

See also the discussions on data and information in the section on Quality Assurance.

2. Diagnosing and investigating health hazards in the community.

Recommendation 21. Determine whether current baseline monitoring efforts are adequate or should be expanded to monitor health risks and outbreaks.

These activities can be categorized into three areas:

- investigation of outbreaks;
- monitoring of chronic or potential hazards to health, particularly environmental and occupational risks; and
- analysis of population-based data sets (as noted above).

The Department of Health and Human Services currently has the capacity and expertise to investigate acute outbreaks and take appropriate action. One area which may be of concern is the ability to monitor new or developing public health risks. The DHHS has participated in an evaluation of health risks caused by environmental factors in conjunction with the New Hampshire Comparative Risk Project and is seeking to develop a similar capacity for work-related injuries and illness. It should be determined whether this level of cooperation between public agencies and between public and private agencies is adequate or should be further expanded to track new and emerging threats to the health of the public.

The DHHS should also work in cooperation with statewide organizations to explore the feasibility of expanding capacity to perform these public health functions at the local level (including the health officer liaison program). The "Turning Point" Initiative will provide preliminary direction for developing this dialog and capacity.

3. Inform and educate people about health issues.

Recommendation 22. Implement improved coordination of health promotion and wellness activities across government agencies, managed care, and other public and private organizations.

New Hampshire has seen substantial activity by public and private agencies and organizations in the area of health promotion and wellness. Many organizations provide the same or similar information in different formats and settings, targeted at specific populations (e.g., teenagers) and specific health issues (e.g., smoking). Overall coordination would ensure that the messages and information are compatible or that important health education/health promotion messages are available to all populations. The DHHS needs to re-evaluate its own health promotion activities in light of the increased private sector participation in health promotion projects; this may also be facilitated by the "Turning Point" initiative.

4. Mobilization of community partnerships and action to identify and solve health problems.

5. Development of policies and plans that support individual and community health efforts.

See Recommendation 25 - Partnering with Communities.

It is in the public interest to provide technical assistance which includes a strong public health orientation. New Hampshire has a long tradition of strong community control and identity and has relied on local initiatives for many of its health system decisions. For example, the Primary Care Initiative (which led to the establishment of community health centers) was an effort initiated by State government in which decisions were made at the local level. The DHHS supports local decision making by providing technical assistance and resources and by seeking out federal support for local efforts.

6. Enforce laws and regulations that protect health and ensure safety.

This function applies to the implementation of the other nine core roles.

7. Linking of people to needed clinical and social services and assurance of the provision of health care when otherwise unavailable.

The Department of Health and Human Services finances a large number of clinical and social services for individuals who are uninsured or underinsured and not able to receive care through the private health care system. These are services that are provided because of failures or inadequacies in the public and private systems. In a perfect world - one in which universal coverage was assured for all citizens for all needed health and social services - public health would not be involved in these services. In the new health care system, if the need for safety net clinical and social services increased dramatically and the State chose to fund these services, other public health functions critical to the new system might be ignored or underfunded.

See also the discussion on Safety Net Providers and Delivery Structures.

8. Assurance of a competent public health and personal health care workforce.

Recommendation 23. Determine the level of support which the State and private entities (such as managed care organizations) ought to provide to public and private health care provider training programs.

This determination should be based on the projected needs of the population. One result of the changes in the organization of health care has been the reduced willingness of provider systems to fund educational/training activities for health care professionals and for research needed to understand and meet the health care needs of the population. Population-based health education has traditionally been under-emphasized in health professional training but if the benefits of managed care are to be realized, providers will have to play a stronger role in educating the general public. Promoting and sustaining population-based education for health and social service professionals is a key public health issue.

The State plays an important role in the training of some health and social services professionals through the University of New Hampshire. In addition, it provides limited targeted assistance to the New Hampshire/Dartmouth Family Practice programs and the Office of Generalist Education at Dartmouth Medical School. Community Health Centers have provided opportunities for primary care education, which will expand with the federally funded statewide Area Health Education Center (AHEC) program - a program targeted to the development of community based professional education.

9. Evaluation of the effectiveness, accessibility, and quality of personal and population-based health services.

In 1996, 39% of New Hampshire's population was enrolled in HMOs (includes underwritten managed care and self funded business). Two current MCOs (CIGNA/HealthSource and Blue Cross/Blue Shield, who purchased Matthew Thornton in 1997) accounted for 77 percent of HMO enrollees in 1996. One of the major differences between indemnity insurance and HMOs is that the former makes a commitment only to pay for health care, the latter is obligated to both pay for the care and arrange for the delivery of that care. The health status of enrollees in an HMO becomes a critical determinant to the financial success of an HMO. As the portion of the population enrolled in HMOs increases, the work of HMOs and public health may overlap. Since the State's residents are rapidly choosing to receive care from two HMOs, these HMOs can - and some would argue should - offer some population-based services that were traditionally provided by public health. In addition, these HMOs might also perform some of the public health evaluations of the effectiveness, accessibility and quality of personal and population-based services. The Turning Point project is a vehicle for considering these changes.

This role was discussed in the section on Quality.

10. Research for new insights and innovative solutions to health problems.

Recommendation 24. Determine the critical areas for public health and policy research and establish criteria for public and private funding.

Concerns have been expressed nationally about the unwillingness or inability of private institutions to support health care research. Emphasis on cost competitiveness and increasing market pressures have forced these institutions to reduce or abandon many of these activities. In the discussion of public health roles, a principal concern is the maintenance of the ability to conduct core research that is in the public interest.

New Hampshire has a variety of organizations which have been established to address the scientific and policy issues for aspects of the health care system. They include the Healthy Communities Foundation established by the Hospital Association, the New Hampshire Public Health Association, the School of Health and Human Services at the University of New Hampshire, the Center for Evaluative and Clinical Sciences at Dartmouth Medical School, and the Department's Office of Planning and Research. The Health Care Transition Fund Community Grant Program has provided an opportunity for a variety of organizations in the State to explore new research and service delivery options.

The development of the *Health Status Indicator Inventory* has raised important questions about the availability of some information and the ability to measure some elements identified as important. There has been an ongoing concern for the need to address all the determinants of health, including the more subjective contributors: safety, social supports, and independence. Research will be needed to develop the factors and methods to collect this data.

⁵³ P. Halverson, "Performing Public Health Functions: The Perceived Contribution of Public Health and Other Community Agencies", *Journal of Health and Human Services Administration*, vol. 18, no. 3, 1996, p.288.

⁵⁴ "Estimated Expenditures for Core Public Health Functions - Selected States October 1992 - September 1993", MMWR, no. 44, vol. 421, 1995. See also R. Brown, A. Elixhauser, et al, National Expenditures for Health Promotion and Disease Prevention Activities in the United States, Battelle Medical Technology Assessment and Policy Research Center, Washington, DC, 1991.

II. Strategies for State Action

D. Partnering with Communities

Last Revised: 11/12/98

District Council members and other participants in the planning work frequently stressed the need for making the voice and the needs of the community an integral part of the new health care system. These discussions raised two basic questions about both communities and the State's involvement:

- What is a community? What is it that the State should be listening to and promoting?
- Why should the State support community involvement in the health care system?

When these questions are fully answered through the planning work, the State can begin to consider how it should assist communities and what form the assistance should take. The State can also determine what it can expect from communities: the way they can balance and augment the actions of the State and the market. This would also allow the State to work with communities to clarify expectations for private entities that claim a community role. For example, non-profit hospitals are described as community organizations that provide community benefits. In return, these institutions do not pay taxes. However, neither the State nor other independent body representing communities has defined the community benefits that non-profits should be providing.

- This section discusses:
- The Definition of Community;
- Importance of Community to the Health Care System;
- Limits of Community;
- The Benefits of Community Discussion;
- Sustaining Community Involvement in the Health Care Delivery System; and
- Defining and Protecting Community Benefits.

Formal and informal community systems of care can be disrupted or destroyed by the actions of government or the competitive nature of markets. The same coordinated and collaborative approaches outlined in the previous sections of this report are used here to propose ways the State can support communities in delivering health care services. The strategies and initiatives are designed to foster community innovation, community participation in the development of health care policy and a common understanding of what constitutes community benefits.

The core strategies in this section are to:

1. sustain community involvement in health care delivery, and
2. define and protect community benefits.

The Definition of Community

"Community" has a number of definitions. In its loosest form, a community is a group of individuals with shared characteristics (e.g., children, the developmentally disabled, health care providers, and the uninsured). As the idea of community becomes more refined, it involves shared space (e.g., the residents of Manchester or the students at any school in the state). In its most sophisticated form, a community involves shared space, interests, language, rights, obligations, values, institutions, resources and world view.

The planning work has focused on communities and community activities that meet three criteria:

1. communities that are webs of social relationships that encompass shared meanings and above all shared values;
2. communities whose members interact on an informal basis; and
3. community activities that are neither dictated by government nor purely a market response.

Within the focus groups and District Council meetings, the involvement of two types of communities were often stressed that meet all of these criteria:

1. local geographic communities that sometimes means towns or cities, and sometimes entire regions, such as the "North Country", and
2. the communities of populations that share common characteristics or needs and who may be drawn into local, regional or statewide associations to provide support to each other and to address common issues and concerns.

The Importance of Communities to the Health Care System

District Council members and participants in the planning process frequently stressed the need for making the voice and the needs of the community an integral part of the evolving health care system. These needs are distinct from the functions and operations of government or the market. Communities are vulnerable to and can be overwhelmed by the power of both government and markets.

The community is often represented by individuals, agencies and firms with complex agendas. Specifically, these representatives of the community can be seen in operation in local government, local business, non-profit agencies and organizations, and as volunteers. They promote their own economic or professional self-interest and the interests of the communities; or represent government's demands as well as their own personal commitment to the well being of the community.

Communities, and organizations representing their communities, demonstrate their absolute or relative importance to the health care system in at least ten ways. Each of these ways was discussed directly or indirectly by the District Councils, during the town forums, and by the focus groups as important reasons for partnering with communities in the development of the health care delivery system. For the most part, these attributes of communities can apply to communities as both geographic entities and associations of individuals who share common characteristics.

1. **Communities represent values that are not necessarily parts of market or government.** In simplistic terms, the best of government may be personified as the proper use of authority, the best of the market as the efficient allocation of wealth and the best of the community as the sweetness of life: compassion, commitment, belonging, forgiveness, trust, loyalty, affection and love.
2. **Some community values and concerns are in direct conflict with markets and government.** For example, from a community perspective, a sick uninsured individual who cannot afford care is not the natural result of demand and supply or a by-product of government's budgetary constraints. The person is a friend or a neighbor whose pain is real within the context of community in a way that is not feasible within the context of government or market.
3. **Communities embody a knowledge of local conditions that are often impossible to incorporate in government procedures and are of no monetary value to the market.** Family members and friends provide much of the care for elders in this country and the individuals providing this care are aware of the unique personal needs of those they are helping. Many elderly patients do not have the financial wherewithal to purchase this care in the market, and state government is unable to track and respond to all individual's unique needs.
4. **Communities provide goods and services that would otherwise be the responsibility of government.** Community action, such as physician services provided through a church group or social services provided through a non-profit women's shelter, can replace services that government would otherwise have been required to provide.
5. **Communities offer a solution to the need for consumer education.**
6. **Communities provide goods and services that are unprofitable and beyond the scope of government but are essential to the well-being of individuals and the**

overall community. Religious groups that do home visiting and volunteers who provide transportation to medical appointments which are not specifically part of a needed medical service are taking the extraordinary step of attending to the well-being of the person and the community.

7. **Communities provide needed goods and services free or below market prices. The millions of dollars of non-reimbursed care that New Hampshire health and social service providers give each year are vital community actions.** Those charitable services would not be available if the providers were solely concerned with maximizing their income.
8. **Communities provide the same goods or services that the market or government provide but do it in a way that reflects the non-market and non-government values of the community.** For example, a non-profit social service agency may provide the identical care as a proprietary entity in the same community. For many of its clients, however, the non-profit agency's relationship with the community is critically important: it is recognized and accepted as a part of the neighborhood and is managed and staffed by neighbors.
9. **Communities are concerned with the general physical, social and economic well being of local residents.** When the community endorses a specific health care action - such as the creation of a local clinic - it does so with an eye to broader concerns. Will it increase jobs? Will the money generated within the clinic circulate within the community? Will the clinic make the community more attractive to potential businesses or residents? Will the clinic enhance a sense of community solidarity (i.e., will it care for the poor as well as the affluent and insured)? All of these actions work towards building the community.
10. **Communities can contribute to social cohesion which improves the health of community members.** Communities with high levels of trust, tight social cohesion and low levels of income disparity tend to have lower mortality rates and less illness than those communities characterized by mutual mistrust, minimum social interaction and great differences in income among its members.⁵⁵

The Limits of Communities

Discussions of communities generally reflected the positive effects that communities can have for their members. However, when discussions became more specific, caveats began to emerge related to the limited perspectives and resources of communities. Thus, while community needs and concerns were always a part of the discussions that took place during the planning work, very rarely did anyone suggest that the "community," in the geographic sense, should control the local health care system, or that, in the population sense, "communities" be viewed as the sole source of information and input for its members. Most participants in the health planning work supported limited and directed community involvement: a community partnership with the State on specific local

programs, preferential treatment of local provider based networks or local control over delivery systems affecting specific groups (e.g., the developmentally disabled). The range of limitations raised included these points:

- there are insufficient resources within communities to set up and monitor a comprehensive system of health care;
- a lack of appropriate leadership accountable to community member;⁵⁶
- disparities in the resources from community to community that would lead to inequities in availability of care; and
- communities could become instruments of intolerance should control become concentrated in a few hands, leading to punitive policies directed at selected populations within a geographic community (e.g., homosexuals and minorities) or within a community of individuals with shared interests or needs (e.g., favoring particular courses of action or care not appropriate to the needs of all members).

Associated with the limitations of communities was the concern that community needs assessments could become dominated by providers and provider agencies that do not understand all of a community's needs or who have intentions that are not shared by the full community. A frequently cited example was physician or hospital dominance in discussions on the health-related non-medical needs of communities.

Not only were the limitations discussed; there was also a call to place limits on community actions, such as:

- a desire that personal decisions and choices on health care and lifestyle be free from judgments that reflect the prevailing standards of the community, and
- communities should not control goods, services, rights or obligations that should apply uniformly to all citizens within the State.⁵⁷

1. Sustain Community Involvement in Health Care Delivery

Changes in New Hampshire's health care and social service delivery system were already under way at the community level, when the national debate on health care reform began. The deinstitutionalization of mental health services, the development of area agencies for the delivery of services to people with developmental disabilities, the efforts to develop family centered children's services, and a shifting of focus from categorical⁵⁸ health care delivery to the delivery of primary care services within a community-based comprehensive care setting predate the recent national health care reform debate. They reflect the efforts of communities to identify better ways of providing services.

Non-profit agencies, advocates for specific population-based communities, and local providers have been instrumental in developing alternative service delivery mechanisms

needed to meet the needs of community members in a way that takes the whole person, family and improvement of the community into consideration.

The early and ongoing movement toward a community-based delivery of mental health care services, primary health care services, services for people with developmental disabilities, and the relatively recent movement toward the development of networks and non-institutional services for the elderly, largely reflects two trends:

- the quest to improve the availability of services to all of the members of a community in a way that reflects family and individual needs, as well as community values, and
- the need to meet the challenges of the evolving health care delivery system, which includes both diminished funding and the emergence of managed care.

As discussed above, communities may lack resources and expertise. On the other hand, they have an important role in the health care system - and as New Hampshire's experience has shown - no lack of ideas and committed citizens. Financial and technical support is necessary to develop and sustain new and innovative community-based approaches.

Recommendation 25. Maintain and protect the Health Care Transition Fund to support innovations in the delivery of health and social services.

State government, and the Department of Health and Human Services in particular, should continue to support the rich tradition of community involvement in meeting the needs of their members. This can be done by offering technical assistance and funding opportunities for community planning activities that include the development of community-focused goals and objectives and new service related initiatives. The New Hampshire Health Care Planning Process has provided an opportunity for individual and community participation and comment in the development of public policies covering a broad range of issues. Part of this effort includes the projects sponsored by the Health Care Transition Fund Community Grant Program.

One of the positive aspects of the Health Care Transition Fund (HCTF) Community Grant Program has been the opportunity for communities to work together and with other State agencies to share ideas, data and innovations that address the health of communities. Some recipients have encouraged the Department to expand its role to include assistance in securing ongoing funding and adoption of those innovations that offer promise in meeting the Department's objectives.

An independent evaluation of the first year of grants awarded by the HCTF Community Grant Program indicates that the projects were successful in addressing the goals of the Program.⁵⁹ By encouraging innovation in the design and delivery of services; in needs assessment and evaluation of service delivery; and in addressing unmet or emerging health concerns, the Department has supported the importance of community-based solutions. Three notable findings from the evaluation are:

- HCTF resources have been effectively leveraged - examples include the \$510,000 Network Development Grant from the Federal Office of Rural Health Policy (Littleton-Berlin areas); the \$480,000 Turning Point grant from the Robert Wood Johnson and Kellogg Foundations (to the NH Public Health Association) and the US Public Health Services grant awarded to the Community Health Access Network (CHAN - an administrative/management network of community health centers).
- Research projects have generated tools and quality-based outcome measures that are available to other community providers to monitor performance and improve quality.
- Grantees have demonstrated a high level of commitment to project continuation (this has been attributed to the fact that the Community Grant Program encouraged innovative and creative proposals to meet local needs).

See also APPENDIX B for a discussion of the Health Care Transition Fund Community Grant Program projects.

Benefits of Community Discussion

When the members of the District Councils were queried regarding the value to them and their organizations of participating in the planning work that resulted in this and the other reports, they acknowledged that the process has been beneficial because it provided a forum for:

- **Communication and Networking.** Participants value the opportunity to meet and get to know other individuals and agencies committed to addressing the health care needs of the community.
- **Input from Diverse Perspectives.** Broad participation of many constituencies brings diverse perspectives that are helpful in identifying and addressing local needs.
- **Reality Testing.** Participants learn about the realities/constraints under which local communities and the State operate. As a result, participants are more sensitive to the complexities under which the State operates which impact public policy development.
- **Learning about State Initiatives/Directions.** Participants are better able to position their agencies if they have a "macro view". That is, they are familiar with the direction in which State policy makers are heading.
- **Communication between Community and State.** The work provides a vehicle for regular two-way communication between the State and community which contributes to greater familiarity with the specific circumstances in the regions as well as with many of the agencies working to meet local needs. In particular, it ensures that a regional perspective is reflected in State policy decisions.

- **Joint Problem-Solving.** Participants engaged in discussions with State policy makers to identify, prioritize, and strategize about issues and problems facing local communities and the State.
- **Input in Public Policy Development.** Participants welcomed the opportunity to have input into formulation of public policy by communicating a local perspective, advocating for the needs of the community, and expressing local preferences for policy options.
- **Time and Attention Dedicated to the Process.** The fact that the State devoted significant resources and time to the process assured participants that their concerns were respected and that their needs will be considered in public policy development and future decision-making.

As the DHHS discusses this document with other stakeholders for review and revision, the above benefits of participation should be duplicated. Some of these stakeholders may participate in the long-term effort by becoming members of the re-designed District Councils, adding to the diversity of input, the "reality testing", and joint problem-solving. Others may become part of an advisory group to the Department of Health and Social Services, the Department of Insurance and the Attorney General's Office for the purpose of monitoring and responding to market behavior.

District Councils

Recommendation 26. Retain the District Councils as a permanent part of health planning and policy development.

The community planning process should continue and the range of functions of the District Councils should include:⁶⁰

- providing a forum for community planning participants to meet regularly and to network;
- providing a forum for community representatives and State policy makers to learn about the realities/constraints under which communities and the State operate; to learn about State and local directions and the needs of various population groups; and to identify opportunities for addressing local and statewide problems;
- providing input into formulation of public policy by giving community planning participants the opportunity to communicate a local perspective, to advocate for the special needs of members and residents, to express preferences and to identify population-specific and region-specific needs and constraints;
- providing feedback regarding implications for the region or population of proposed initiatives;

- assisting in identifying feasible and realistic strategies which employ local or available resources to achieve goals;
- advocating for the community at the State level to support the successful implementation of broad goals and objectives;
- monitoring and providing feedback to the State regarding the impact of public policy on the community and the degree to which intended outcomes are being met;
- serving as a liaison and advocate between the State and the communities by sharing information; and
- facilitating "buy-in" by the community in implementing goals and objectives.

These District Council participants did not, however, envision a role for the community based planning effort in direct implementation of the strategies. The group anticipated an oversight role - monitoring the impact of State and local response and providing feedback regarding the status of implementation efforts.

2. Define and Protect Community Benefits

Recommendation 27. Develop operational standards for community benefits (with representatives from communities, non-profit providers, and representatives from the Department of Insurance and the Office of the Attorney General) that reflect community values.

Non-profit organizations have historically dominated the hospital sector, health maintenance organizations and social service organizations. A non-profit organization may be owned and controlled by those who use it (the members) or may be a mutual⁶¹: (a company with a non-membership self-perpetuating board). The primary distinction between a non-profit and a for-profit firm is the that non-profit cannot distribute net earnings (or any increase in its net worth) to individuals who exercise control over the entity. Non-profits receive a sizable public subsidy in the form of tax forgiveness. They are exempt from federal income tax, state and local income taxes, sales tax and property tax. Non-profits are eligible for specific tax free bonds. They also receive preferential tax treatment for charitable gifts (that is, when the non-profit receives donations, the donor may claim those gifts as a tax deduction).

The general public often makes two false assumptions about non-profits. The first is that they cannot make a profit. In fact, non-profits can generate profits as long as they direct the proceeds back into the services that meet the mission of the organization.⁶² The second misconception is that non-profits have to provide charitable services. For most non-profits in the health care field - those who have 501(c)(3) tax status - all the services have to be legal and in accordance with "religious, charitable, scientific, testing for public

safety, literary, or educational purposes." Charity would be nice but is not explicitly required.⁶³

Non-profits have been viewed as essential in health care because many believe that non-profits derive their rewards by embodying the principles of altruism, compassion and service. The belief is that they offer services to the community that would not be made available by proprietary firms. While that belief tends to be supported by assessments of the non-profits' contributions to their communities, that experience is not uniform. There are instances when proprietary firms provide more benefits to their communities than non-profit institutions.

This blurring of community contributions originates with the dual function of non-profits. They are both community organizations and economic entities. Money matters to their survival. If the resources are not available, the non-profit will not be able to meet its mission. Therefore, non-profits represent a hybrid entity; one that is assumed to primarily serve the community while also operating as a seller in the market that competes with other non-profit, proprietary and government firms.

The fear that the power of markets may overwhelm the community aspects of non-profits is one of the forces that has prompted a movement for a clear articulation of the community benefits that citizens should expect from their non-profit organizations.

With the passage of SB 101 (the nonprofit healthcare merger bill) in the 1997 session of the legislature, New Hampshire has begun to examine the relationship of community benefits (the rewards to the community that accrue with the granting of tax-exempt status to a non-profit organization) and ownership status. When a conversion of an entity from a non-profit to for-profit occurs or when a non-profit transfers more than 25% of its assets to another non-profit certain steps must be taken, including public notice and comment prior to the governing board votes on the transaction.

New Hampshire currently has no law, consensus or policy as to what constitutes community benefits. Non-profit status may no longer be a good proxy for community benefits, and the opportunity costs to the State are considerable. Funds that are lost through the tax exempt status of a non-profit that performs few community benefits could have been redirected to new efforts committed to meeting community needs.

The work needed to identify community benefits requires identification of community activities in health care and proceeds from two perspectives. The first is consideration of an objective record of the activity as indicated within the financial books and accounts of an organization and the second is consideration of how the organization is viewed within its community. Since both the State and communities have vested interests in the process, both should be involved.

⁵⁵ From a public health perspective, New Hampshire has the good fortune of having comparatively high levels of trust, low levels of income disparity and low levels of mortality rates. I. Kawachi, B. Kennedy, and K. Lochner, "Long Live Community: Social Capital as Public Health", *The American Prospect*,

November/December 1997, pp.56-59.

⁵⁶ Particular concerns were expressed over the ability of local governments to manage the delivery of health care services. Even though local governments were not seen as the answer, individuals could not come up with an entity outside of government (e.g., a locally formed network) that they would assign that function.

⁵⁷ There was disagreement on this point among those who viewed local government as having a role in protecting the public's health, a point which was generally conceded by those who raised the objection. Those who held this view argued that a municipality's "public health" role and the delivery of health care services to individuals were distinct and discrete, and that the operation of a care delivery system was not an appropriate responsibility for local government.

⁵⁸ A health service or program restricted to a single population (e.g., child health clinics or screening women for breast cancer) due to State or federal funding requirements.

⁵⁹ Health Care Transition Fund Community Grant Program: Evaluation of First Round Grantees; Community Health Institute, January, 1998.

⁶⁰ These recommended functions were drawn from the District Council discussions of October, 1997, that was facilitated by Susan Friedrich of the Community Health Institute and reported in *Components of a Community-Based Planning Process* dated November 1, 1997.

⁶¹ A mutual is a form of corporate organization without stockholders, in which members proportionately share profits or losses, expenses, etc.

⁶² Bradford Gray (ed.), *For-Profit Enterprise in Health Care*, Institute of Medicine, Washington, DC, National Academy Press, 1986, p. 8.

⁶³ Mark Schlesinger, Bradford Gray and Elizabeth Bradley, "Charity and Community: The Role of Nonprofit Ownership in a Managed Health Care System," *Journal of Health Politics, Policy and Law*, Vol. 21. No. 4, Winter 1996, p 712.

Appendix A. Acknowledgements

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District Council Membership ***The Honorable Raymond Burton***

Pam Albee – Ossipee
David Allison – Cornish
Julia Assur – Lebanon
Elizabeth Baker –
Meredith
James Baker – Bethlehem
Gordon Bartlett – Belmont
Kim Bedor - St. Johnsbury
Mary Beshta – Bristol
Mary Bidgood-Wilson -
Center Harbor
Lawrence Bienemann-
Bethlehem
Virginia Blackmer –
Sanbornton
Andy Blodgett – Lisbon
Peter Blue – Conway
Christopher Boothby –
Nashua
Tina Borrin –
Moultonborough
J. Bowers-Cross –
Randolph
Larrie Bratko – Whitefield
Catherine Burke –
Littleton
Dottie Burrows – Conway
Theresa Buteau –
Lancaster
Ella Casey – Newport
Gene Chandler – Bartlett
Mary Choate – Laconia
Thomas Chrimes –
Newport
Gerry Coogan - North
Conway
Kevin Cooney – Newport

Betsy Davis – Lebanon
Lorraine Demers - No
Haverhill
Tom Donovan –
Claremont
Carol Dustin – Lebanon
Alex Easton – Berlin
Gerald Ellsworth –
Claremont
Lori Foster – Lancaster
Art Froberg – Berlin
Shirley Ganem –
Wolfeboro
Pam Gile – Lebanon
Tina Grecco – Franconia
Diann Greene – Plymouth
Paul Grenier – Berlin
Eugenia Hamilton –
Lebanon
Harold Harbour –
Northfield
Laurie Harding – Lebanon
Winona Hardy – Tilton
Peter Higbee – Berlin
Don Holl – Claremont
Lynn Horton – Lancaster
Godfrey Howard - Mirror
Lake
Deanna Howard –
Lebanon
Donald Isabelle – Laconia
Larry Jasper – Gilford
David Jescavage –
Newport
Carl Johnson – Meredith
Kathy Jones – Tilton
Lori Karr – Hanover

Lawrence Kelly – Berlin
Fred King – Colebrook
David King – Laconia
Ann Kitson – Berlin
Sandra Knapp – Glencliff
Donald Kollisch –
Hanover
Kimon Koulet - Meredith
Bernard Kramer –
Meredith
Doreen Kusselow –
Claremont
Vicki Lane – Berlin
Maryellen LaRoche –
Ossipee
William Lepis – Bartlett
Paul Lodi - North Conway
Carl Lord – Berlin
Randy Lyman – Ossipee
Jane MacKay – Littleton
Les MacLeod – Wolfeboro
Sharon Malenfant - No
Conway
Melanie Mardin –
Plymouth
Lynn Markle – Littleton
Stan Marsden – Conway
Patricia Martin – Lebanon
Leah Mason - Center
Ossipee
Dee McClave – Jackson
Marge McClellan – Berlin
Gail Merrill – Claremont
Lorraine Mellow –
Littleton
Claudia Messier – Laconia
Alida Milham – Laconia

Bert Mills – Sunapee
Edith Mongo – Meredith
Maxine Morse – Laconia
Bernadette Nay –
Jefferson
Merelise O'Connor –
Plymouth
Dennis O'Leary –
Meredith
Susan Orkin – Concord
Jim Ostroski – Newport
Bruce Pacht – Lebanon
Steve Pangoulis - No
Haverhill
Michele Patten – Littleton
Robert Pearson – Littleton
Dee Peterson – Chocorua
Patsy Pilgrim – Lancaster
James Pilliod – Belmont
Joseph Pimental – Easton
James Pisciotta – Bedford
Peter Powell – Lancaster
Leslie Ramsey - No
Haverhill

Cathy McDowell –
Gorham
Willis Reed – Claremont
Beverly Rodeschin –
Newport
Anthony Rodrigues –
Littleton
Pat Rogers – Lancaster
Bob Rowen - Center
Sandwich
Sue Ruka - North Conway
Mary Ruppert – Littleton
Debra Ryder – Lancaster
Ben Sanders – Meredith
Donna Sargent - Ctr
Ossipee
Don Saunders – Berlin
Merle Schotanus –
Grantham
Roxie Severance –
Whitefield
Brenda Shannon – Easton
Scott Shipman - New
London

Sally Small – Franconia
Kathleen Smith – Littleton
James Somerville –
Conway
Sean Stevenson –
Claremont
Jonathan Stewart –
Littleton
Roland Stoodley –
Newport
Jesse Turner – Lebanon
James Varnum – Lebanon
Gil Vickery – Franconia
Richard Wahrlich –
Claremont
Rodney Walker – Newport
Marge Webster – Ossipee
Sheila Weeks – Laconia
Ralph Wiggin – Conway
John Will - North Haverill
Jay Wolter – Haverhill
Adele Woods - Berlin

The Honorable Peter Spaulding

Tricia Brooks – Concord
Judith Bush – Boscawen
Bonnie Cohen – Rochester
Steve Colombo – Concord
Michael Delucia –
Concord
James Doremus – Concord
Mike Dumond – Concord
Karen Dutcher –
Rochester
Alex Feldvebel – Concord
Barbara French –
Henniker
Lawrence Ford – Concord
Anne Fugagli – Concord
D. Gaudreault-Larochelle
– Goffstown
Glenna Goodman –
Henniker
Michael Green – Concord

Monica Haley –
Somersworth
Linda Hotchkiss –
Farmington
Shari Landry –
Manchester
Margaret Landsman –
Concord
Terry Lochhead – Concord
Susan Lynch – Hopkinton
Thomas Matzke –
Boscawen
Cindy Miner – Concord
Susan Palmer-Terry –
Concord
Lucretia Richmond –
Warner
Ellen Sheridan – Concord
Richard Silverberg –
Franklin

Gary Sobelson – Concord
Rod Tenney – Concord
Roberta Terrill – Bow
Tony Thibodeau –
Concord
Mary Trinkley – Concord
Dan Vachon –
Somersworth
Mary Jane Wallner –
Concord
Donna Ward-Tetley –
Franklin
Ellen Wheatley – Bow
Chuck Wiesen – Rochester
Sue Wnuk – Concord
Donna Woodfin –
Concord
Rob Yager – Concord
Susan Young – Concord

The Honorable Ruth Griffin

Catherine Becallo – Dover
Lynn Berggren – Dover
Noreen Biehl – Dover
Judy Bunnell –
Portsmouth
Gertrude Butler – Fremont
Trinka Callaghan-Russell
– Stratham
Kevin Callahan – Exeter
Jeff Connor – Portsmouth
Kathleen Crompton –
Exeter
Joe Diamant – Hampton
Joanne Dodge – Dover

Greg Ginchereau –
Brentwood
Jackie Ham – Dover
Betsy Hersam – Exeter
Robert Hersam – Exeter
Marc Hiller – Durham
Murray Ingraham – Dover
Patricia Jillette – Dover
Lindsay Josephs – Rye
Valerie Long – Durham
Linda McCabe – Dover
Deborah Merritt – Durham
Sarah Oxnard –
Newmarket

Pam Raley – Portsmouth
Doreen Raymond – Dover
Luanne Rogers –
Portsmouth
Karen Scanlon – Salem
D. Schnappauf –
Portsmouth
Bill Schuler – Portsmouth
K. Suyematsu –
Hampstead
Susan Turner – Concord
Pat Wood – Rye

The Honorable James Normand

Beverly Arel – Bedford
Judson Belmont –
Manchester
Constance Benoit –
Manchester
Donald Benoit –
Manchester
Elaine Benson –
Manchester
Maria Borduz –
Northwood
Paul Boynton –
Manchester
Troy Brown –
Londonderry
Ed and LuAnn
Brueggemann –
Londonderry
Jane Cappannelli –
Manchester
Ruth Carleton –
Londonderry

Selma Deitch –
Manchester
Cora Der Koorkanian –
Manchester
Clark Dumont –
Manchester
Eileen Ehlers –
Manchester
O. Gabardina –
Manchester
Ed George – Manchester
Marie Gross – Manchester
Gale Hennessey –
Manchester
Sandy Hicks – Manchester
Lezley Hunger – Concord
Mary Ann Knowles –
Hudson
Dr. Cindy Lanzara –
Nashua
P. Leonard-Schwartz –
Manchester
Lisa Lyons – Manchester

Richard Marchand –
Manchester
Paula Marzloff – Auburn
J. Matuszewski –
Manchester
Clem Mayo – Manchester
Joyce Meisel – Concord
John Merrick –
Manchester
Mary Mongan –
Manchester
James Murphy –
Manchester
Albert Provencher –
Manchester
Louise Provencher –
Manchester
Martha Roy – Raymond
Fred Ruszcek –
Manchester
Ken Snow – Manchester
Sylvia Tenn – Manchester
Jane Wilkalis – Derry

The Honorable Bernard Streeter

Carl Amelio – Nashua
Darlene Ayotte - East
Sullivan
Harriet Babcock – Keene
Vivian Barry – Milford
Dolly Bellavance –
Nashua
Richard Berry –
Goffstown
Leslie Boggis – Hollis
Elizabeth Brown – Rindge
Griffin Dalianis- Nashua
Lisa Davenport – Stoddard
Kim DeTour - Newton
Junction
Leonard Dobens – Nashua
Tom Donovan – Newport
Lee Farina – Keene
Kenneth Ferron – Nashua
Eric Forrest – Merrimack
Jane Garry – Hancock
Margaret Gilmour –
Nashua

Peter Gosline –
Peterborough
A. Haettenschwiller –
Nashua
Roger Hebert – Nashua
Joyce Heck – Nashua
Leanne Henderson –
Nashua
Owen Houghton – Jaffrey
Richard Ingram – Nashua
David Irwin –
Peterborough
Kevin Johnson –
Westmoreland
Kenneth Jue – Keene
Arlene Kershaw –
Manchester
Tom Link – Keene
Donnalee Lozeau –
Nashua
Georgie Lyons – Amherst
Mariellen MacKay –
Nashua

Patricia Mandravelis –
Nashua
Jeanne Marcoux – Nashua
L. McFarland –
Westmoreland
Leslie Melby – Concord
Frank Niro – Peterborough
Kay Noel – Nashua
Gertrude Pearson – Keene
Sandra Pelletier – Nashua
James Potter –
Peterborough
Dennis Rivet –
Peterborough
Donna Storrs – Hollis
Janice Sylor – Nashua
Thomas Taylor –
Peterborough
Mary Vallier-Kaplan –
Hollis
Donald Zizzi – Nashua

Focus Group Participants

The following names are professionals representing the following groups: Advocacy, Alliance for the Mentally Ill of NH, Developmentally Disabled, Elder Care, Health Care, Health Providers, Home Health Care, Hospital Association, Maternal and Child Health, Medical, Social Service, and State Agencies.

Adcock, Ron
Andrew, Mark
Bazos, Dottie
Bidgood Wilson, Mary
Boulter, Suzanne
Brady, Meghan
Brooks, Tricia
Bullock, Susan
Burr, Charlie
Cantor, Edda
Ciolfi, Monica
Clough, Polly
Dan, Paul
Davis, Steve

Deltario, Maria
Fair, Pat
Felgar, Alvin
Flynn, Mary
Friedman, Steve
Friedman, Steve
Friedman, Richard
Frydman, David
Gladstone, Wendy
Gordon, Steve
Guild, Jill
Hamilton, Eugenia
Helms, Ned
Howard, Deanna

Johnson, Joyce
Jones, Palmer
Karmeris, Susan
LaRoche, Maryellen
Learned, Richard
Louney, Dan
Mailloux, Ray
McMahon, Chris
Melby, Leslie
Melkonian, Gregory
Merrithew, Dana
Millham, Alida
Mongan, Mary
Moore, Judy

Moyer, Karen
Neuschatz, Joel
Paras, Artemis
Pelillo, Ingrid
Pellitier, Sandy
Peters, Ann
Petersen, Rick
Piet, Jim
Pitman, Alyson
Porembski, Alice
Powell, Phyllis
Robichaud, Alan
Romanowicz, Eileen

Ruppert, Mary
Ryan, Philip
Sanders, Jeanne
Schuler, William
Seiden, Margaret
Sherman, Rick
Simon, Mitch
Singlais, Larry
Slagle, Julie
Sobelson, Garry
Sowerby, Dwight
St. Germain, Norma
Steir, Linda

Straw, Peggy
Terry, Clyde
Tobey, Gerald
Tobin, John
Turner, Susan
Vidaver, Virginia
Williams, Norrine
Wnuk, Sue
Yager, Robert
Young, Susan
Young, Karen

Town Forums (towns and number of attendees which totaled 635)

Lancaster 90
Claremont 80
Laconia 30
Keene 45
Peterborough 30
Nashua 200
Milford 50
Manchester 45
Portsmouth 45
Salem 20

HMO Executives

Harris Berman
David Jensen
Everett Page
Norman Payton

Department of Insurance

Monica Ciolfi
David Sky
Robert Warren
Colin Mitchell
Deborah O'Laughlin

Department of Education

Joyce Johnson

Attorney General's Office

Michael DeLucia
Walter Maroney

Technical Review and Consultation

Richard Curtis, Executive Director, Institute for Health Policy Solutions, Washington, DC

Randy DeSonia, Director, Health Policy Studies, National Governor's Association, Washington, DC

Robert DiPrete, Director, Health Council, Oregon Health Plan

Elliot Fisher, MD, MPH, Dartmouth Medical School

Susan Friedrich, Executive Director, Community Health Institute, Concord, NH

Alice Hersh (late), CEO, Association for Health Services Research, Washington, DC

Judith Miller Jones, Director, National Health Policy Forum, Washington, DC

Russell Jones, Former Medical Director of Public Health Services

Dick Merritt, Director, Intergovernmental Health Policy Project, National Conference of State Legislators, Washington, DC

Rosemary Orgren, Assistant Professor, Community & Family Medicine, Dartmouth Medical School

Karl Polzer, Senior Research Associate, National Health Policy Forum, Washington, DC

Jeffrey Prottas, Associate Director, Institute for Health Policy, Heller School, Brandeis University, Waltham, MA

Mark Schlesinger, Yale University, New Haven, CT

Bruce Spitz, Independent Consultant, Former Professor of Health Policy, Brandeis University

Jonathan Stewart, Managing Director, Ammonoosuc Family Health Services

Colleagues in Other States

Kansas

Steve McDowell, Executive Director, Rural Health Associates, Lawrence, KS

The People in the Communities of Minneapolis and Wellington, KS

Michigan

Pamela Paul-Shaheen, Executive Director, Comprehensive Community Health Models, Okemos, MI

Representatives from the Michigan Department of Health and Medicaid

Minnesota

Shari Konerza, Director, Office of Rural Health and Primary Care, Minnesota Department of Health, St. Paul, MN

Molly McCormick, Network Development and Technical Assistance Program in the Office of Rural Health and Primary Care, Minnesota Department of Health

Kathleen Vanderwall, Data Forecasting Unit, Minnesota Department of Health

Ira Muscovice and Jon Christianson, Rural Health Research Center, Institute for Health Services Research, School of Public Health, University of Minnesota

Vermont

Anya Rader, Executive Director, Vermont Program for Quality Health Care, Montpelier, VT

Maggie Moran-Green, Deputy Commissioner, Vermont Department of Health, Burlington, VT

Theresa Alberghini, Deputy Commissioner, Vermont Bureau of Health Care Administration, Montpelier, VT

Washington

Vicki Wilson, Health Policy Research and Development, Washington Health Care Authority, Olympia, WA

Appendix B. Health Care Reform in New Hampshire: 1986-1998

Last Revised: 11/12/98

1986-1990 Medical Indigence and Access to Care

During this period, the debate on medical indigence and the uninsured began. The New Hampshire Task Force on Indigent Care described New Hampshire as being "on a collision course with the reality of medical indigence" and expressed concern that the ability to cost-shift was disappearing.¹ A few years later a legislative subcommittee called for the State to "measure the problem ... then to have the solution divided between the public and private sectors."² In response, an Advisory Council to Governor John Sununu recommended that the Department of Insurance develop a generic, low-cost health insurance plan, and that a survey be conducted to determine the nature, extent, and characteristics of the uninsured population in New Hampshire.³

As a result, a 1989 study of the uninsured in New Hampshire was conducted. The report *Health Insurance Coverage in New Hampshire: The Problem and Its Effect on Access to Medical Care*, concluded that:

- two distinct populations were not covered by health insurance in New Hampshire - individuals who worked for firms that did not offer coverage and those who lacked sufficient income to purchase coverage regardless of employment status; and
- the cost of treating the uninsured was being borne by all providers and payers of health care.⁴

The study recommended that the State set up group purchasing arrangements for small employers and develop a subsidized program for those whose incomes were below the federal poverty level but were ineligible for Medicaid. (Single adults or couples without children do not qualify for Medicaid unless they are disabled or elderly.)

The Committee on Access to Health, established soon after the study on the uninsured was released, was charged with overseeing the preliminary steps for improving access within the State.⁵ The Committee identified barriers to implementing such a program, including "... a perceived attitude that the uninsured are someone else's responsibility ... and no sense that the State has responsibility to offer such a program to its citizens and to finance it."⁶

The State implemented several of the Committee's recommendations to improve access to care: Medicaid was expanded for children and pregnant women, comprehensive primary care clinics were established, and health promotion activities were funded. Tabled recommendations included the establishment of a basic health benefit insurance product, the creation of an insurance fund for the uninsured, and the appointment of a permanent body to continue to study the access problem.

1990-1995 Health Reform and Health Planning

During the early 1990s, the State expanded its concern for the uninsured and underinsured. Commissioner Harry S. Bird adopted a broad vision of health reform. The *New Hampshire Health Care Reform Plan* was proposed in 1994 with a series of House and Senate bills that devised an infrastructure for reform and created the New Hampshire Health Care Transition Fund for the purpose of transitioning the State to the National Health Care reforms over the next six to seven years.⁷

Legislation was also passed that created small group and individual insurance market reforms (SB 711), mandated community rating (modified only for age)⁸, guaranteed issue and renewability, and narrowed restrictions on pre-existing conditions. New Hampshire's reforms in the individual market (prior to Kennedy-Kassenbaum passage) were rated as the most comprehensive in the country.⁹

SB 774 allowed for the expansion of Medicaid eligibility up to 185% of the Federal Poverty Level for children and pregnant women and increased coverage of children in this expanded category up to 19 years of age. New Hampshire was only 1 of 8 states at the 185% level and 1 of 13 states that extended eligibility up to age 19.¹⁰ SB 775 also directed the State to seek Medicaid waivers that would allow adults (who were otherwise not eligible) with incomes below the Federal Poverty Level to participate in Medicaid. Another Medicaid waiver was also sought to provide preventive home and community-based services for the elderly and adults with disabilities through SB 625.

As part of the New Hampshire Health Care Reform Plan, access issues for vulnerable populations were addressed in SB 791. That act called for an expansion of primary care clinics for low income people, continuation of primary care provider recruitment and retention efforts, expansion of services for children with chronic and mental illness, and expansion of substance abuse treatment. The Department of Health and Human Services also planned to request a Medicaid waiver that would garner federal funding for low income workers (referred to as a Medicaid "buy-in"). Further, it established an Office of Health Planning.

All of the above legislation was predicated on the belief that federal reform would be successful, and that the New Hampshire plan would complement the Federal Health Security Act of 1994 over the next six years. Many of these reform efforts were never implemented because of funding questions and the demise of National Health Care Reform.

In January 1995, Commissioner Terry L. Morton was confirmed. He reviewed the current status of health care planning given the changed environment brought about by the demise of President Clinton's Health Care Reform. With Governor Merrill's support, he introduced HB 60 which became the Department's blueprint for a new approach to health care delivery in New Hampshire. HB 60 restructured the Health Care Transition Fund. Instead of spending \$12 million a year for six years, the original intent was modified to create a fund that would exist in perpetuity, protecting the principal while using the

interest earnings for health care initiatives. Each year \$7 million would be available to fund the State's Medicaid expansion, services to chronically ill children, primary care clinics, provider recruitment and retention efforts, and development of a health planning capacity (the Office of Planning and Research was established in the fall of 1995 and charged with the responsibility for the Health Care Planning Process). HB 60 also created the Community Grant Program - a funded partnership between the State and local communities to support innovative approaches to health care.

During the first half of this decade, the private sector was also assessing health care reform in New Hampshire. The New Hampshire Hospital Association, in collaboration with the Medical Society, the Home Care Association, the Business and Industry Association, and the Commissioner of Health and Human Services developed a vision for health system reform in New Hampshire.¹¹ Their report included a work plan to carry out the recommendations, one of which was to expand the health reform process into a broad-based, participatory and fact-based project. Other recommendations included insurance coverage for a standard benefit plan for all State residents, continuation and expansion of the health status measures in the DHHS's *Primary Care Access Plan* (currently titled the *Primary Care Access Data*) creation of a collaborative, voluntary organization to produce and disseminate data on health care cost and quality, and transition of the health system to a fully capitated model with universal coverage for all State citizens.

1995 - 1997 Recent Developments in Health Care Reform

While planning for the long term was in process, the State began to take steps necessary to deal with the near future of health care delivery in New Hampshire. Efforts to protect consumers received increased attention. During the 1996 legislative session, a measure was passed prohibiting managed care insurers from having "exclusive arrangements" with providers.¹² The Attorney General's Office, Antitrust Division, examined the development of new delivery system entities such as Integrated Service Networks (ISNs) and Physician Hospital Organizations (PHOs) while the Department of Insurance considered a new formula for solvency requirements for risk-bearing entities.¹³ SB 101 (the nonprofit health care merger bill) passed in the 1997 legislative session. This bill codified the role of the Director of Charitable Trusts, in the Attorney General's Office, in dealing with both for-profit acquisitions of charitable healthcare organizations and nonprofit-to-nonprofit consolidations. SB 178 - also from the 1997 legislative session - was the State's first effort at regulating managed care organizations.

During this period, the State had the opportunity to gauge the impact of an earlier reform - SB 711 (which changed the rules for the small group and individual insurance markets). The Department of Insurance commissioned a study on the effects of this legislation on premium rates, the uninsured population and insurance availability. Results released in December, 1997, indicated that the reform legislation was successful and substantially met all of its objectives. It assured "availability" and eliminated "job lock" without evident adverse effects on "affordability".¹⁴

Present Initiatives for Health Reform

Prior to and during the Health Care Planning Process, the State was pursuing a number of additional health care reform initiatives. These initiatives will be further developed as part of the action steps to implement the strategies laid out in the ***Guidelines for Change***. They include the Medicaid Managed Care Waiver, the Health Care Transition Fund Community Grant Program, the Long Term Care Plan and a related Pilot Demonstration, the development of a solution for the problems in the Non-Group insurance market and the formation of purchaser coalitions (such as the New Hampshire Healthcare Purchasers Roundtable).

Medicaid Managed Care Waiver/Buy-In. Many states have created Medicaid Managed Care programs to improve access to and quality of care for Medicaid enrollees, while at the same time creating a more predictable cost structure for Medicaid than exists under the present fee-for-service program.

The State filed in June 1996 with the Health Care Financing Administration (HCFA) for a waiver of federal Medicaid regulations which would allow the State to implement a managed care program for all participants in Transitional Assistance to Needy Families (TANF) and related groups (the largest number of participants would be women and children). Existing federal Medicaid regulations require states to treat all population groups enrolled in Medicaid alike (women and children, the elderly, blind and disabled).

The Medicaid Waiver could also provide a financial vehicle to expand coverage to all children in New Hampshire who currently lack access to health insurance benefits (adults would be considered after children).

See section on Subsidizing Private Market Coverage for a detailed discussion of this topic.

Community Grant Program. The Community Grant Program is funded from interest earned by the Health Care Transition Fund. It is moving into its fourth year of funding community initiatives that encourage creative approaches to address health care needs. The mission of this program is to promote access, improve the quality of health care services, evaluate service delivery and cost models, and improve the purchasing and cost effective utilization of health care services. To date the Department has funded 103 projects worth \$10 million. These projects have dealt with a number of areas:

Uninsured and the Underserved. The community grants program has funded projects addressing the needs of the uninsured and the underserved. Approaches vary from underwriting a unique and creative medical service access program for migrant laborers to enabling community health centers to test new ways to serve individuals and families throughout the State who cannot afford adequate health insurance.

Dental Care. These projects serve persons in settings as varied as Manchester's downtown neighborhoods and rural Sullivan County. While their primary target group is children, underserved and uninsured persons of all ages are also included. Varied strategies are employed including school-based clinics, hospital-initiated programs, and community outreach.

Network Support. Grants have been used to help emerging community-based networks meet an array of medical and social service needs. One example is the development work underway to adapt and produce software that will enable network members, or a set of networks, to develop a "single point of entry" process. Resources have also been provided to enable one of the horizontal networks to develop a common accounting system.

Long Term Care Plan for the Medicaid Population. The State plans to tackle problems in the long term care system on three fronts - the Legislature, the DHHS and the elder care system. Suggested legislation includes extending the moratorium on new nursing home beds to December of 2001, permitting Medicaid funding for residential care and providing for adult foster care homes that care for one or two patients. On the administrative side, proposals include changing nursing home rate setting standards to reflect the acuity of care and expanding mid-level of care services within the community in order to reduce the need for more expensive nursing home beds. This draft five-year plan lists a number of pilot projects, such as gradually expanding congregate housing statewide,¹⁵ shared housing¹⁶ and the Cheshire County Pilot Demonstration described below.

Dual-Eligibles Cheshire County Pilot Demonstration. The term Dual Eligibles refers to those adults who are eligible for Medicaid through a category other than Transitional Assistance to Needy Families (TANF) (e.g., disabled consumers) and adults who are eligible for both Medicare and Medicaid (the State pays Medicare premiums for low income elders who cannot afford them through the Medicaid Program). The proposed demonstration involves approximately 1,200 of the 13,000 dually eligible persons in the State. The ultimate goal is to integrate the full range of existing community-based services and delivery systems, both acute and long term care, under a capitated financing structure. The Cheshire County demonstration will pre-test all aspects of the planned New Hampshire model for a fully integrated service delivery system for the entire dual eligible population. The new system will be person-centered and will focus on wellness and the positive capacities of each person served regardless of the type or degree of disability the person carries. Services will be delivered locally by integrated service networks which include all provider types necessary to insure the availability of all services currently provided under Medicare and Medicaid and any new services which evolve.

Risk Adjustment for the Non-group Market. The cost of health insurance for many individuals in the non-group market in New Hampshire has been escalating sharply. This market has such a small number of covered lives (the vast majority of the insured population participate in group insurance plans), hence, little opportunity to spread risk

among participants and keep premiums affordable. As premiums increased, healthier consumers dropped coverage, which led to a further increase in rates for the persons remaining who were generally less healthy (escalation of premiums while lower risk consumers drop coverage is referred to as a "death spiral" in the insurance business). This was particularly true for Blue Cross and Blue Shield of New Hampshire which had the largest number of covered lives, the higher risk enrollees, and the highest premium increases. The result - Blue Cross and Blue Shield withdrew from the non-group market effective January 1, 1998.

As a short term measure, the New Hampshire Insurance Department is attempting to stabilize the non-group market by implementing a risk adjustment and subsidy mechanism. All health insurance carriers in all markets will be assessed an amount that is based on their number of covered lives. The fund generated in this manner will be used to offset catastrophic expenses for high cost enrollees among carriers that currently offer health insurance policies in the non-group market. This strategy represents an effort to stabilize the non-group market by spreading the risk of high-cost enrollees beyond this small market.

New Hampshire Healthcare Purchasers Roundtable. The Department of Health and Human Services is an active participant in the New Hampshire Healthcare Purchasers Roundtable. The Roundtable is a partnership of public and private health care purchasers working together to ensure health care that is accessible, affordable and of high quality. Some of the objectives of the Roundtable include:

- responding to growing health care market consolidation by bringing public and private purchasers together around an active, consumer-oriented agenda;
- promoting value-based purchasing by building into the purchasing process criteria that address quality as well as cost;
- working collaboratively with providers and health plans to develop common standards and mechanisms for data collection and performance evaluation;
- working collaboratively with providers and health plans to promote continuous improved performance and coordinated action to address identified community needs; and
- educating purchasers and consumers of health care services.

¹ Final Report of the NH Task Force on Indigent Care, June, 1986. "Cost-shifting" or "across subsidy" occurs when one patient, e.g., a privately insured patient, is charged more than their costs in order to pay for another patient that was uninsured.

² Subcommittee Report on HB 1116, September 30, 1988.

³ Final Report of the Health Insurance Fund Advisory Council, November, 1988.

⁴ Medical Care Development, Inc., *Health Insurance Coverage in New Hampshire: The Problem and its Effect on Access to Medical Care*, Augusta, ME, December, 1989.

⁵ The Committee on Access to Health Care, December, 1990.

⁶ The Committee on Access to Health Care, December, 1990.

⁷ New Hampshire Health Care Reform Proposal, December, 1993.

⁸ Community rating is a method of calculating health insurance premiums using the average cost of actual or anticipated health services for all subscribers within a specific geographic area. The premium does not vary for different groups or subgroups of subscribers on the basis of their specific claims experience.

⁹ Barents Group, LLC, *State Regulation of the Individual Insurance Market*, Washington, DC, National Institute for Health Care Management, May, 1996.

¹⁰ National Governor's Association, *State Medicaid Coverage of Pregnant Women and Children*, Washington, DC, September, 1996 and Center on Budget and Policy Priorities, *Early Childhood Programs Can Make Medicaid Work For Children*, Washington, DC, October, 1996.

¹¹ NH Hospital Association, *Joint Task Force on NH Health Reform*, Concord, NH, 1994.

¹² Chapter 420 - I, 134:2, 1996.

¹³ National Association of Insurance Commissioners, *DRAFT Health Organization Risk-Based Capital (HORBC)*, June, 1997.

¹⁴ J. Lee, N. McCall, C. Liu, R. Freitas, B. Hart, L. Kirsch and R. Goldstein. *An Investigation into the Effects of the New Hampshire Reform Law, 420-G*. Center for Health Economics Research and IMR Health Economics, LLC. Concord, NH, December, 1997.

¹⁵ NH currently has a Congregate Housing Services Program (CHSP) which delivers supportive services (in low-rent housing with a central dining facility) that enable frail elderly and non-elderly incapacitated adults to maintain their independence and avoid institutionalization.

¹⁶ Shared housing includes "adult family care services" which consist of care and assistance provided in an adult family care home to an elderly or disabled individual who, by reason of physical or mental disability, would be in an institution if not for these services. This model is based on foster care for children.

Appendix C. Index to Recommendations

Last Revised: 11/12/98

A. Promoting Access To Health Coverage While Controlling Costs

Recommendation 1. The Department of Health and Human Services, the Department of Insurance and the Office of the Attorney General, together with market participants, should jointly monitor and respond to market behavior.

Recommendation 2. Monitor the uninsured and underinsured to track the effectiveness of the changing market in addressing their needs.

Recommendation 3. Consider establishing a standardized set of benefit packages for the health insurance market.

Recommendation 4. Consider establishing a risk adjustment system for the health insurance market.

Recommendation 5. Establish a statewide health insurance purchasing alliance for small employers and for individuals.

Recommendation 6. Provide a subsidy for the purchase of private insurance coverage for those who are uninsured because they cannot afford it.

Recommendation 7. Determine the scope of "safety net" services that should be available, the necessary level and sources of funding to maintain these services, and who should provide the services.

Recommendation 8. Support and promote systems that coordinate health-related non-medical services with medical care to improve outcomes.

Recommendation 9. Revise the role of Certificate of Need to keep pace with the rapidly changing health care market.

Recommendation 10. Work with communities, market and provider representatives to establish both minimum standards of adequacy for the delivery system and a process and incentives for encouraging providers to practice within medical shortage areas or areas that do not meet minimum standards of adequacy.

B. Protecting And Empowering Consumers

Recommendation 11. Establish an independent mediator, with the authority to make recommendations, for disputes arising among consumers, providers, health insurers and managed care organizations.

Recommendation 12. Create an independent consumer hotline for complaints regarding health insurance coverage.

Recommendation 13. Promote and participate in an organization which would develop innovative quality monitoring and improvement activities.

Recommendation 14. Develop a coordinated monitoring policy for all health care services for which there is current State Legislative or regulatory authority.

Recommendation 15. Develop the capacity to provide data that allows citizens to review the health status of communities and the statewide population; to understand the performance of State and market functions; and to understand the status of community concerns.

Recommendation 16. Promote the private development of information that helps improve the health status of New Hampshire citizens and the operation of the health care system.

Recommendation 17. Establish licensure for health care organizations that bear financial risk based on a formula that adjusts capital and reserve requirements to the number of covered lives served by an organization, its structure, and the percent of risk that the organization will assume.

Recommendation 18. Develop guidelines governing the transfer of financial risk from one entity to another.

Recommendation 19. Establish the capacity to track the number of self-insured plans, require such plans to disclose to their enrollees that they are self-insured, and provide support and guidance to individuals insured under such plans.

C. Re-Defining Public Health

Recommendation 20. Collaborate with the Turning Point Steering Committee to reassess the functions of public health.

Recommendation 21. Determine whether current baseline monitoring efforts are adequate or should be expanded to monitor health risks and outbreaks.

Recommendation 22. Implement improved coordination of health promotion and wellness activities across government agencies, managed care and other organizations.

Recommendation 23. Determine the level of support which the State and private entities (such as managed care organizations) ought to provide to public and private health care provider training programs.

Recommendation 24. Determine the critical areas for public health and public research and establish criteria for public and private funding.

D. Partnering With Communities

Recommendation 25. Maintain and protect the Health Care Transition Fund to support innovations in the delivery of health and social services.

Recommendation 26. Retain the District Councils as a permanent part of health planning and policy development.

Recommendation 27. Develop operational standards for community benefits, with representatives from communities, non-profit providers, and representatives from the Department of Insurance and the Office of the Attorney General, that reflect community values.

Public Comment Form

Last Revised: 11/12/98

Your comments on the final draft of "The New Hampshire Health Care System: Guidelines for Change" are important to us.

1. Do you support the Vision and Values? ___Yes ___No (See pages 5 - 11) Comments:

2. Do you support the Goals? ___Yes ___No (See pages 11 - 12) Comments:

3. Which recommendations are most important to you? Please reference them by #1-27.

4. Which recommendations are least important to you? Why? Please reference them by #1-27.

5. Do you have any other comments? Please use the reverse side of this form.

6. Would you like to participate in our work with the community councils to improve New Hampshire's health care system? ___Yes, please contact me.

Name:

Organization:

Address:

Telephone:

Email:

Fax:

Thank you for completing this Public Comment form.

Name and Telephone # (Optional)